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The

WISCONSIN MEDICAL JOURNAL

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STATE MEDICAL SOCIETY of WISCONSIN

A Monthly Journal of Medicine and Surgery

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VOLUME LVIII
JANUARY 1959–DECEMBER 1959

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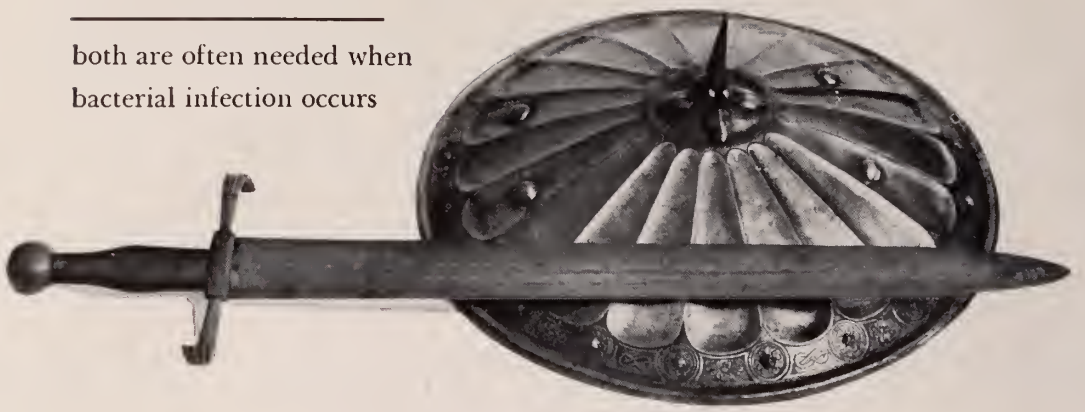

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Doctor Middleton's Dreams of a New Medical School Library Are Materializing

An architect's drawing of the proposed medical school library building is shown above. The building will be approximately 170 feet by 70 feet and will have two floors and a basement. It will be called the William S. Middleton Medical Library.

The University of Wisconsin Medical Alumni Association has announced the successful opening of its campaign to raise $850,000 for a medical school library. It has been organized on a national basis to raise funds from fellow alumni and friends of the school to provide a badly needed medical library and to honor Dr. William S. Middleton, long-time Professor of Medicine and former Dean of the University of Wisconsin Medical School, now on leave to serve as Medical Director for the Veterans Administration.

On October 1, 1958, the William S. Middleton Medical Library Fund Drive was officially opened and the results of the organized campaign are just beginning to materialize. Over $110,000 in gifts and pledges have been received to date. This amount, together with the $70,000 pledged prior to the fund drive, accounts for a total of $180,000. Doctor Middleton, for whom the library was a fond hope, had raised much of this $70,000 before he left Wisconsin. The ultimate goal of the fund drive is $850,000.

An architect's drawing of the proposed medical library building is shown here. The building will be approximately 170 feet x 70 feet, consisting of two floors and a basement. It will include seating space for 200 (including 36 carrels—6 closed, 30 open), shelf space for 120,000 bound volumes and shelf space for the 10,000 unbound volumes which comprise the Medical Library Service. This service, worked out by the School with the State Medical Society and the U. W. Extension Division is in keeping with the University of Wisconsin idea of service to the entire state and community. It provides Wisconsin physicians with answers to their medical questions and is also available to laymen. Lawyers and industrial workers are heavy users. In addition to this stack space, there will be work space and mailing space for the staff and a special room for the valuable Historical Collection.

The present book collection exceeds 62,000 bound volumes, including an exceptional number of rare medical volumes. Adequate facilities are needed to meet the space demands of 1,100 students in the Medical Center, including medical students, nursing students, interns and residents, therapists, medical technologists and graduate students in the health sciences.

The Wisconsin Medical Alumni Association was organized in 1956. This is the first major project undertaken by this organization. Area chairmen have been appointed for the solicitation of funds. They are: Drs. Mischa Lustok, Milwaukee; A. R. Curreri, Madison; Silas Evans, Milwaukee; Adolph Hutter, Fond du Lac; Leslie Kindschi, Monroe; Howard Lee, Milwaukee; Eugene Nordby, Madison; David Ovitt, Milwaukee; Carl W. Schmidt, Waterloo; S. E. Sivertson, La Crosse; Wm. Smiles, Ashland; Joseph Stone, Milwaukee; J. H. Wishart, Eau Claire; Wm. Konnak, Racine; and R. P. Welbourne, Watertown.

Area alumni meetings have been scheduled. A meeting will also be held during the annual meeting of the State Medical Society in Milwaukee on May 5–7.

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(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

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Many Scientific Exhibits to Be Displayed at 1959 Annual Meeting, May 5, 6 and 7

The Council on Scientific Work has approved the following scientific exhibits, which will be available for study in the Exhibit Hall throughout the three-day meeting:

DETECTION AND MANAGEMENT OF PHENYLKETONURIA
Stanley Berlow, M.D., Children's Hospital, Milwaukee

REPAIR OF NASAL DEFECTS WITH EAR LOBE GRAFTS
Frank Bernard, M.D., D.D.S., and **Gordon Davenport,** M.D., Dept of Surgery, U. of W. Medical School

DIAGNOSIS AND SURGICAL MANAGEMENT OF ACQUIRED VALVULAR HEART DISEASE
Richard J. Botham, M.D., Dept. of Surgery, U. of W Medical School

ULCEROGENIC TUMOR OF THE PANCREAS
E. H. Ellison, M.D., Dept. of Surgery, Marquette University School of Medicine

THE USE OF TIDAL DRAINAGE IN THE BLADDER TRAINING OF PATIENTS WITH CORD LESIONS AND OTHER NEUROLOGICAL DISABILITIES
R. W. Boyle, M.D., Marquette University School of Medicine, Milwaukee County Hospital, and VA Hospital, Wood

DIAGNOSTIC AND THERAPEUTIC PROGRAMS AT MILWAUKEE HOSPITAL
Staff of Milwaukee Hospital

CAUSES OF HEMOPTYSIS
O. F. Foseid, M.D., **J. W. Messer,** M.D., and **W. L. Waskow,** M.D., Jackson Clinic, Madison

CINEFLUOROGRAPHY OF THE HEART
William J. Gallen, M.D., Children's Hospital, Milwaukee

SMALL VESSEL ANASTAMOSIS
Marvin Glicklich, M.D., Dept. of Surgery, Marquette University School of Medicine

REDUCTION OF INTRACRANIAL PRESSURE WITH UREA SOLUTION
M. J. Javid, M.D., Dept. of Surgery, U. of W. Medical School

SEGMENTAL CONSOLIDATION OF THE LUNG
J. Richard Johnson, M.D., VA Hospital, Madison, and Wisconsin Anti-Tuberculosis Association

SODIUM AND POTASSIUM HOMEOSTASIS IN INFANTS AFTER GASTROENTERITIS
Gerald A. Kerrigan, M.D., Children's Hospital, Milwaukee

POLAROID PHOTOGRAPHS ON SURGICAL SPECIMENS (Demonstration)
E. S. Olson, M.D., St. Luke's Hospital, Racine

DIRECT SURGERY OF THE PERIPHERAL ARTERIAL TREE
John T. Phelan, M.D., Dept. of Surgery, U. of W Medical School

SPECIAL RESEARCH PROJECTS AT COLUMBIA HOSPITAL, MILWAUKEE
Gorton Ritchie, M.D., and Associates

PRIMARY AND SECONDARY PLASTIC REPAIR OF INJURY
Sidney K. Wynn, Dept. of Surgery, Marquette University School of Medicine

---

In addition to the above exhibits approved in December, there will be a coordinated exhibit on cancer by the Wisconsin and Milwaukee Divisions of the American Cancer Society, and a Gross Tissue Demonstration by members of the Wisconsin Society of Pathologists. Additional scientific exhibits will be announced as they are approved.

RECESS DEMONSTRATIONS AND MOVIES

Supplementing the scientific exhibits and the Glaucoma Testing Station there will be medical motion pictures and selected demonstrations at recess periods These will be announced as program details are completed.

NOON LUNCHEONS TO BE CONTINUED

The traditional noon Round Table Luncheons will be scheduled for Tuesday through Thursday. Few scientific luncheons will be held on Tuesday since at that time the alumni groups of both the University of Wisconsin Medical School and Marquette University School of Medicine will meet at the Milwaukee Auditorium Full details of the luncheons will be carried in the March issue of THE WISCONSIN MEDICAL JOURNAL and through special announcements to members

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Bigger 1959 SAMA Scientific Assembly Planned

Students, Interns and Residents Urged to Participate

Medical students, interns and residents are being urged to participate in the second annual national Scientific Exhibit Assembly of the Student American Medical Association to be held in Chicago next April.

The program was inaugurated in 1958 and is dedicated both to the contributions of medical students to research and to the advancement of the scientific exhibit as a primary medium of communication in the profession. It is hoped that new physicians will contribute to their colleagues' knowledge through exhibits and papers throughout their medical careers.

Arrangements have been made for more space to hold a total of 40 scientific exhibits, the best work presented in this medium of professional communication by the country's outstanding students, interns and residents. Of these, 20 will be by students and 20 by interns and residents.

The SAMA-Lakeside Laboratories Awards will again be given, with the special honor of free all-expense trips to the American Medical Association convention and the privilege of exhibiting in the AMA's own world-famed scientific assembly, for the top student and the top intern or resident.

Cash prizes and plaques will be given, with $500, $250 and $100 for award-winning exhibits by students; and $500, $250 and $100 for those by interns and residents. Lakeside Laboratories supports the awards and the trips to the AMA.

A distinguished group of judges will again make the decisions.

SAMA believes this program is a real opportunity for all medical colleges and teaching hospitals—students, faculty and hospital staff alike—to report on their work nationally and to be recognized for their contributions to new medical knowledge.

Applications must be obtained from SAMA (address Mr. Russell Staudacher, Executive Secretary, Student American Medical Association, 430 North Michigan Avenue, Chicago 11, Illinois) and returned no later than February 1, 1959. On February 14, the 40 chosen exhibitors will be announced. These must complete their exhibits and ship them to Chicago at their own expense, for inclusion in the SAMA scientific assembly, April 30–May 2.

Space and basic materials such as backdrop, table, chairs and lighting, will be provided free by SAMA.

Last year, SAMA was particularly pleased that the top award-winning exhibit by a student, Quinton Callies of Wisconsin, was also exhibited at the American Trudeau Society, as well as at SAMA and AMA, and the study was published in the JOURNAL OF THE AMA.

Wanted! Photos of Wisconsin Physicians

At Work

In Research and Teaching

In History

In Public Service

At Play

Make your plans now to send a photo of yourself or a colleague to the State Medical Society for entry in the annual Wisconsin Physicians Photography Exhibit to be displayed at the annual meeting in May. Photos will be placed in one of five classes which are listed at the left. This is a project of the Society's Charitable, Educational and Scientific Foundation, Inc., in cooperation with the Section on Medical History. For information about the exhibit and a set of rules, write: State Medical Society, Box 1109, Madison 1, Wisconsin.

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Provides terpin hydrate, classic expectorant to thin inspissated mucus and help the patient clear the respiratory passages.

†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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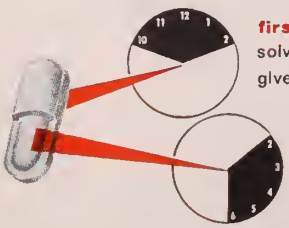

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Medical Meetings - Postgraduate Courses

Aero Medical Association

The thirtieth annual meeting of the Aero Medical Association will be held April 27–29, 1959, at the Statler Hotel in Los Angeles, California. Charles I. Barron, M.D., of Lockheed Aircraft Corporation is general chairman. Further information may be obtained from: Secretary of the Air Force, Office of Information Services, Los Angeles Branch, 6085 Sunset Boulevard, Hollywood 28, California.

American Board of Obstetrics and Gynecology

The next scheduled examinations (Part II), oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 8 through 19, 1959. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

Current Bulletins of the American Board of Obstetrics and Gynecology, outlining the requirements for application, may be obtained by writing to the Secretary: Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

American College of Allergists

The American College of Allergists Graduate Instructional Course and Annual Congress will be held March 15–20, 1959, at the Mark Hopkins Hotel in San Francisco, California. Contact: John D. Gillaspie, M.D., Treasurer, 2049 Broadway, Boulder, Colorado.

American College of Chest Physicians

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present the twelfth annual postgraduate course on Diseases of the Chest at the Sheraton Hotel, Philadelphia, March 30–April 3, 1959.

The most recent advances in the diagnosis and treatment of heart and lung diseases, medical and surgical aspects, will be presented.

Tuition for this five-day course will be $100, including luncheon meetings.

Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

American College of Surgeons

Medical meetings for 1959 of the American College of Surgeons are as follows:

January: Sectional Meeting, Francis Marion Hotel, Charleston, South Carolina, January 19–21. Dr. Kenneth M. Lynch, Jr., Charleston, Local Chairman. Dr. Michael L. Mason, Secretary, 40 East Erie Street, Chicago 11, Illinois.

February: Sectional Meeting, Shamrock Hilton Hotel, Houston, Texas, February 2–4. Dr. J. Griffin Heard, Houston, Local Chairman, Dr. Michael L. Mason, Secretary, 40 East Erie Street, Chicago 11, Illinois.

Sectional Meeting, Hotel Vancouver, Vancouver, B. C., February 26–28. Dr. T. R. Sargeant, Local Chairman, Dr. Michael L. Mason, Secretary, 40 East Erie Street, Chicago 11, Illinois.

March: Four-Day Sectional Meeting for Surgeons and Nurses, Kiel Auditorium, St. Louis, Missouri, March 9–12. Dr. Frank McDowell, St. Louis, Local Chairman for Surgeons Meeting, Miss Joyce Brueggeman, R.N. Local Chairman for Nurses Meeting. Dr. Michael L. Mason, Secretary, 40 East Erie Street, Chicago 11, Illinois.

April: Four-Day Sectional Meeting for Surgeons and Nurses, The Queen Elizabeth Hotel, Montreal, Quebec, April 6–9. Doctors Harry S. Morton and Charles Edouard Hebert, Montreal, Local Chairmen for Surgeons Meeting, Miss Moyra Allen and Sister Denise Lefevre, Montreal, Local Chairmen for Nurses Meeting. Dr. Michael L. Mason, Secretary, 40 East Erie Street, Chicago 11, Illinois.

September: Annual Clinical Congress, Atlantic City, New Jersey, September 28–October 2. Dr. Michael L. Mason, Secretary, 40 East Erie Street, Chicago 11, Illinois.

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Association of American Physicians and Surgeons

The sixteenth annual meeting of the assembly and delegates of the Association of American Physicians and Surgeons will be held April 2, 3, and 4, 1959, at the Hilton Hotel in Fort Worth, Texas.

Chicago Ophthalmological Society

The Chicago Ophthalmological Society will hold its annual clinical conference on February 13 and 14, 1959 at the Drake Hotel in Chicago, Illinois.

Guest speakers will include Dr. Paul A. Chandler, Boston, Massachusetts, Dr. Charles E. Iliff, Baltimore, Maryland, Dr. Samuel J. Kimura, San Francisco, California, Dr. John Harry King, Washington, D. C., Dr. J. V. Cassady, South Bend, Indiana, Dr. J. Robert Fitzgerald, Chicago, Dr. Wm. F. Hughes, Chicago, Dr. Gilbert Iser, Chicago, Dr. Bertha Klien, Chicago, Dr. Frank W. Newell, Chicago, Dr. R. Charles Oldfield, Oak Park, Illinois, Dr. John H. Olwin, Chicago, Dr. Frank Pirrucello, Evanston, Illinois, and Dr. Theodore Zekman, Chicago.

Subjects will include a symposium on the management of surgical conditions of lids and lacrimal apparatus, management of uveitis, prophylaxis and treatment of vascular occlusions, plastic surgical principles, clinical value of electroretinography, management of cardiac arrest and glaucoma management, and present status of preserved eye tissue for transplantation.

Registration fee for the entire course, including round table luncheons and buffet supper, is $45.00 and may be payable to the Registrar: Mrs. Edward J. Ryan, 1150 North Lorel Avenue, Chicago 51, Illinois.

The fifteenth annual Sanford R. Gifford Memorial Lecture will be delivered by Dr. Paul A. Chandler of Boston, Massachusetts, on Friday, February 13, 1959, at the Drake Hotel at 5:15 P.M. All ophthalmologists are invited to attend the Gifford Memorial Lecture and the buffet supper which follows.

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North Shore Hospital Lecture Series

The fifth lecture in the ninth annual North Shore Hospital lecture series on "Emotional Forces in the Family" will be held at the hospital, 225 Sheridan Road in Winnetka, Illinois, on Wednesday, February 4, 1959, at 8:00 P.M. "The Impact of Relatives and In-laws" will be discussed by Nathan W. Ackerman, M.D. He is associate clinical professor of psychiatry of Columbia University, president of the Association for Psychoanalytic Medicine, and a fellow of the New York Academy of Medicine.

The Commission on Education of the American Academy of General Practice has approved these lectures for Category II credit. Doctor Ackerman will answer any questions after his presentation. All physicians and allied professional personnel are welcome to attend.

Southwestern Society of Nuclear Medicine

The Southwestern Society of Nuclear Medicine will hold its fourth annual meeting at the Roosevelt Hotel in New Orleans, Louisiana, March 14–15, 1959. For further information write: Samuel B. Nadler, M.D., Chairman, Program Committee, 1520 Louisiana Avenue, New Orleans 15, Louisiana.

University of Minnesota Continuation Courses

Medical continuation courses to be presented at the Center for Continuation Study at the University of Minnesota are as follow:

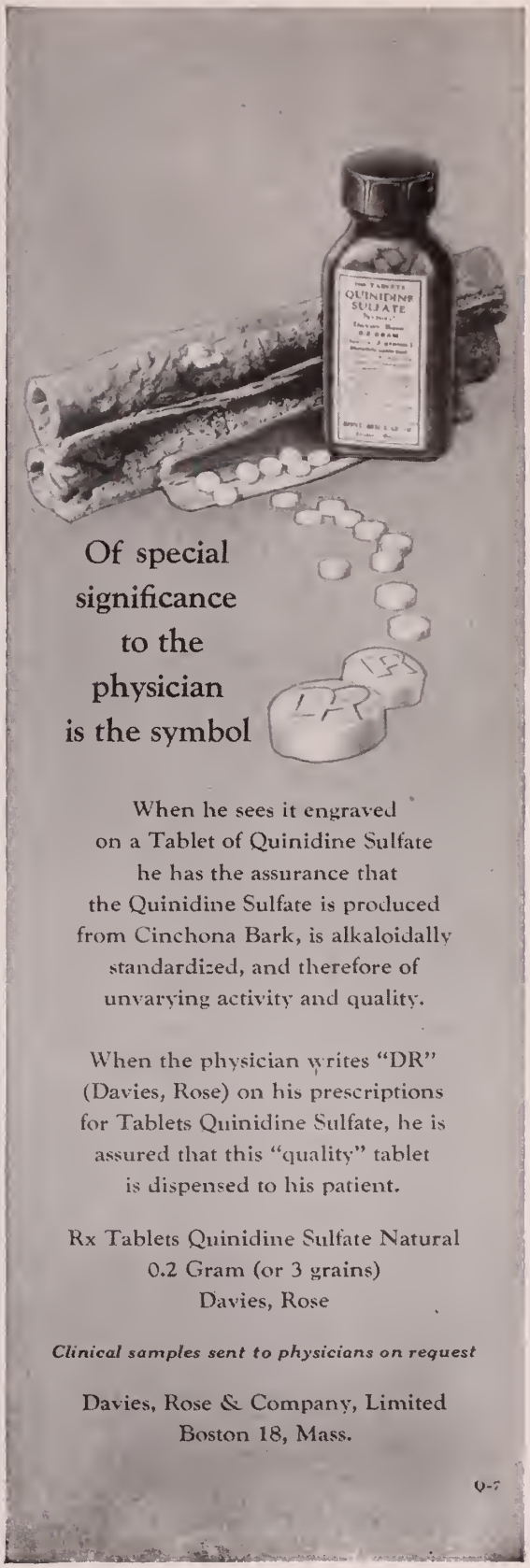
- February 23–25: Cardiovascular Diseases for General Physicians
- March 2–4: Pediatrics for General Physicians
- March 14: Trauma for General Physicians
- March 16–18: Internal Medicine for Internists
- March 30–April 3: Basic Concepts of Water and Electrolyte Balance for General Physicians

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

PLAN NOW TO ATTEND

SMS Annual Meeting

MAY 5-6-7, 1959



SPONTIN IN SERIOUS

A Special Report from Abbott to the Medical Profession on a Year's Clinical Experience with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem—and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

Abbott

STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases — "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children — "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.
4. J. A. M. A., 167:1584, July 26, 1958.
5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.
6. Billow, F. J., et al., Clinical Observations on Ristocetin—A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.
7. Miller, J. M., et al., Ristocetin in the Treatment of Seven Selected Difficult Cases, In Press, Antibiotics Annual, 1958-59.
8. Asay, L. D., et al., Ristocetin Serum Levels in Children, In Press, Antibiotics Annual, 1958-59.
9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.
10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

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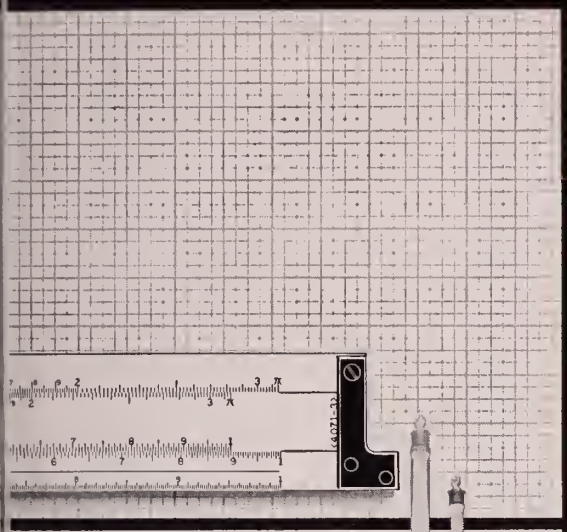

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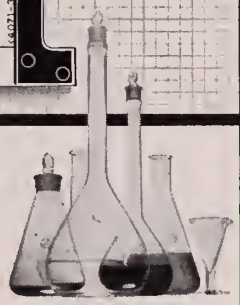
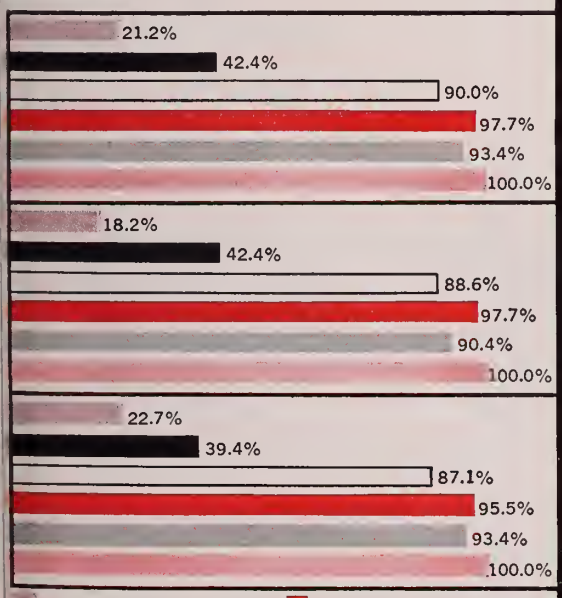


over 90% effective against resistant staph

COMPARATIVE TESTS BY THREE METHODS (DISC, TUBE DILUTION, CYLINDER PLATE) ON 130 STAPHYLOCOCCI[9]



Antibiotic A 2-10 units
Antibiotic B 5-30 mcg.
Antibiotic C 5-30 mcg.
TAO 2-15 mcg.
Antibiotic D 2-15 mcg.
Antibiotic E 5-30 mcg.

Percentage of organisms inhibited by the range of concentrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed—stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity—freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults**, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

TAOMID* (TAO with triple sulfas)

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For direct action—in clinical emergencies.

Supplied: In 10 cc. vials.

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W., Ashland	C. A. Grand 520 W. Second, Ashland	
Barron–Washburn–Sawyer–Burnett	D. G. MacMillan 13. S. Main Rice Lake	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	Donel Sullivan 305 E. Walnut Green Bay	Frank Urban 305 E. Walnut, Green Bay	Second Thursday°
Calumet	J. M. Guthrie 302 Cleveland, Brillion	J. W. Knauf Chilton	
Chippewa	B. J. Haines Cadott	R. L. Hendrickson 12 Third, Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	C. F. Broderick Wisconsin Dells	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	L. E. Holmgren 30 S. Henry St., Madison	A. P. Schoenenberger 122 W. Washington, Madison	Second Tuesday Sept. through June
Dodge	G. G. Drescher 106½ Front Beaver Dam	Andrew Vrabec 302 N. Spring Beaver Dam	Last Thursday°
Door–Kewaunee	J. F. March 413 4th, Algoma	A. S. Lanier 3rd & Ellis, Kewaunee	
Douglas	R. T. Anderson 1507 Tower, Superior	L. R. Rosin 2231 E. Fifth, Superior	First Wednesday°° Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand, Eau Claire	K. E. Walter 131 S. Barstow, Eau Claire	Last Monday
Fond du Lac	E. W. Vetter 80 Sheboygan Fond du Lac	R. W. Schroeder 39 S. Main Fond du Lac	Fourth Thursday°
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	H. L. Doeringsfeld Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	L. G. Kindschi 1770 13th, Monroe	J. A. Frantz Monroe Clinic, Monroe	
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	J. C. Russell 38 S. Water, W. Ft. Atkinson	H. W. Aufderhaar 38 S. Water Ft. Atkinson	Third Thursday°
Juneau	V. M. Griffin Hess Clinic Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	John B. Pearson 624 57th Street Kenosha	Mr. L. F. Jost, Ex. Sec. Box 669, Kenosha	First Thursday° Elks Club
La Crosse	J. R. Richter 203 Fifth Ave. S., La Crosse	P. C. Dietz 1020 Market St., La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane 123 E. Ann, Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	J. E. Garritty Antigo	First Monday
Lincoln	R. G. Baker Tomahawk	H. G. Adams 110½ W. Wisconsin Tomahawk	
Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building, Manitowoc	D. A. Kuljis 1606 Washington Two Rivers	Last Thursday
Marathon	J. V. Flannery 808 Third, Wausau	T. C. Burr, Jr. Fifth and Jefferson Wausau	
Marinette–Florence	Clarence H. Boren 1510 Main, Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	J. S. Devitt 944 N. Jackson Milwaukee	E. M. End 7608 W. State, Wauwatosa Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main, Oconto	C. E. Siefert Oconto Falls	
Oneida–Vilas	W. K. Simmons 1020 Kabel, Rhinelander	Marvin Wright 1020 Kabel, Rhinelander	Monthly
Outagamie	H. T. Gross 103 W. College Appleton	W. A. Dafoe 103 W. College Appleton	Third Thursday° Elks Club
Pierce–St. Croix	P. S. Haskins River Falls	P. H. Gutzler River Falls	Third Tuesday

°° Except July and August. ° Except June, July and August.

(Continued on next page)

List of Officers and Scheduled Meetings of County Medical Societies *(Continued)*

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Polk	M. E. Wegner St. Croix Falls	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	W. C. Sheehan 755 Strongs, Stevens Point	W. A. Gramowski 319½ Main, Stevens Point	
Price–Taylor	W. W. Meyer 410 S. Second, Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	L. J. Kurten 810 Main Racine	W. H. Williamson 1101 Grand, Racine	Third Thursday
Richland	George Parke 323 S. Central Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	J. C. Springberg 405 E. Grand Beloit	R. L. Chancey 1146 Grant Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	G. W. Zauft 590 Fourth Prairie du Sac	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	L. W. Peterson Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	R. A. Wood 1011 N. Eighth Sheboygan	R. M. Senty 1011 N. Eighth, Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	E. P. Rohde Galesville	J. H. Noble 912 Harrison Black River Falls	Fourth Tuesday
Vernon	H. E. Oppert 318 S. Main, Viroqua	R. A. Starr Viroqua	Last Wednesday
Walworth	W. C. Woods 607 Walworth Delavan	H. M. Levin Delavan	Second Thursday*
Washington–Ozaukee	H. J. Katz 11 Center Cedarburg	R. H. Dorr Belgium	Fourth Thursday
Waukesha	James V. Bolger, Jr. 102 E. Main, Waukesha	Philip Wilkinson 618 W. La Belle, Oconomowoc	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon, Oshkosh	G. B. Hildebrand 59 Racine, Menasha	First Thursday
Wood	W. L. Nelson 480 E. Grand Wisconsin Rapids	J. R. Heersma 650 S. Central, Marshfield	Four times a year

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References: 1. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 2. Eisenberg, B. C., Clinical Medicine *5*:897-904 (July) 1958. 3. Robinson, H. M., et al.: J.A.M.A. *161*:604-606 (June 16) 1958. 4. Robinson, H. H., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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County Society Proceedings

BARRON–WASHBURN–SAWYER–BURNETT

At a recent meeting of the Barron–Washburn–Sawyer–Burnett County Medical Society, officers were named for the 1959 term. They are: *Drs. D. G. MacMillan*, president; *Emil Krueger*, vice-president; *H. M. Templeton*, secretary–treasurer and delegate; and *W. B. Rydell*, alternate delegate.

BROWN

The Brown County Medical Society elected officers for the ensuing year at a meeting held December 11. Those chosen are:

Donel Sullivan, President
J. A. Killins, President-elect
Frank Urban, Secretary–treasurer
L. C. Miller, Delegate
Raymond Waldkirch, Delegate
John Ford, Alternate delegate
Stewart Griggs, Alternate delegate

DANE

Members of the Dane County Medical Society met December 9 at SMS headquarters. The meeting consisted of a panel discussion by the cardiovascular department of the University of Wisconsin with *Dr. C. W. Crumpton* as moderator. The title of the discussion was, "Evaluation and Disposition of Congenital Heart Disease."

Officers of the society are: *Dr. L. E. Holmgren*, 30 South Henry Street, president; *Dr. F. E. Mohs*, University Hospitals, president-elect; *Dr. P. B. Golden*, 110 East Main Street, vice president; and *Dr. A. P. Schoenenberger*, 122 W. Washington, secretary–treasurer, all of Madison.

Dr. F. J. L. Blasingame, executive vice president of the A.M.A., was the guest speaker at the January 13 meeting of the Dane County Medical Society. His subject dealt with medical–economic problems.

DODGE

Twenty members of the Dodge County Medical Society attended a meeting held at Waupun Memorial Hospital on November 20. Speaker for the evening was *Dr. Leonard Schrank* of Waupun who talked and presented movies on his Alaskan hunting trip.

During the business session the group discussed the examinations of athletes in the high schools. They, also, revised the Dodge County Welfare Schedule and the Dodge County Communicable Disease Clinics. Also on the business agenda was the appointment of *Dr. G. G. Drescher* to the office of President and *Dr. Andrew Vrabec* to Secretary–treasurer.

On December 20 the county society members and their wives had a Christmas party.

Physicians whose names are printed in italics are members of the Society.

JEFFERSON

The monthly business meeting of the Jefferson County Medical Society was held December 18 at Radtke's Tea Room. The annual election of officers was held with the following physicians chosen:

Dr. James C. H. Russell—President
Dr. C. Quandt—Vice-president
Dr. H. Aufderhaar—Secretary
Dr. R. Quandt—Delegate
Dr. H. G. Mallow—Alternate delegate
Drs. O. H. Hanson, S. H. Ambrose, and *R. P. Welbourne*—Censors
Drs. C. G. Maloney and H. W. Aufderhaar—Public health representatives

Twenty-four members attended the meeting and heard a talk by *Dr. Bruce Brewer*, Milwaukee. Dr. H. W. Aufderhaar was accepted as a new member.

JUNEAU

New officers of the Juneau County Medical Society who assumed their positions in 1959 are:

V. M. Griffin—President
J. H. Vedner—Vice-President
M. S. Tverberg—Secretary–Treasurer

LAFAYETTE

On December 2 the following officers of the Lafayette County Medical Society were named for 1959:

D. H. Garland—President
R. E. Oertley—Vice-President
N. A. McGreane—Secretary–Treasurer
R. E. Oertley—Delegate
R. E. Hunter—Alternate delegate

Doctor Oertley was also named medical representative to the County Board.

LINCOLN

At a recent meeting *Dr. Rowe Baker* was named president, *Dr. Edward Jarvis* vice-president, and *Dr. Harold Adams* secretary–treasurer of the Lincoln County Medical Society for the coming year.

MILWAUKEE

The Medical Society of Milwaukee County held a meeting January 8 at the Wisconsin Club. A conference on infant deaths which occur in the first few hours after birth was participated in by Drs. John R. Wolff, Chicago, Illinois; Woodruff L. Crawford, Rockford, Illinois; and *Amy Louise Hunter*, Madison. Moderator of the program was *Dr. Paul S. Pierson*, Milwaukee.

OUTAGAMIE

On October 16 the Outagamie County Medical Society held its regular monthly meeting at Riverview

(continued)

LETTERS
TO THE MEDICAL DIRECTOR

Dear Doctor:

Rauvera* was used on five patients with essensential hypertension varying from moderate to severe. The highest blood pressure was 220/130 and the lowest 180/105.

All patients have shown a consistent response to the drug and the continuation therapy has effected a good control so far . . . approximately two to three months. In four patients systolic blood pressure was reduced from 20 to 50 mm. Hg and the diastolic from 10 to 15 mm. One patient, who had a pressure of 220/130 has had a phenomenal response, and I brought the systolic down to 165 and the diastolic to 95.

M. D., Wisconsin

Dear Doctor:

Rauvera has produced satisfactory reductions of blood pressure in every hypertensive case in which I have used it.

M. D., Colorado

Dear Doctor:

Rauvera tabs are my choice for hypertension over 170 . . . they give me the best results.

M. D., Texas

Comment: *It is interesting to note that no adverse side effects were reported in connection with Rauvera's effective antihypertensive action.*

*Rauvera contains 1 mg. alseroxylon (purified Rauwolfia serpentina alkaloid), 3 mg. alkavervir (Veratrum viride fraction) in each scored tablet.

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COUNTY SOCIETY PROCEEDINGS (continued)

Sanitorium in Kaukauna. Business for the evening consisted of the election of officers and formation of a library committee to correlate staffs, requirements, costs, etc., of three hospitals. The 46 members attending also heard a report from the public relations committee.

Guest speaker at the November 20th meeting of the Outagamie County Medical Society was *Dr. A. E. Schultz* of Wisconsin General Hospital, Madison. The subject of his talk was "Treatment and Diagnosis of Carcinoma of the Female Genital Tract."

A committee was formed to review and study the customary fee contracts of Wisconsin Physicians Service following a discussion on that subject by the membership. During the business meeting it was announced that the Appleton Jaycees will present an award to the outstanding man of the year.

The December meeting of the society was held on the 18th at the Elks Club in Appleton. A social hour followed by dinner and professional entertainment was provided for the doctors and their wives.

POLK

Dr. and Mrs. *W. A. Fischer* were hosts at a dinner meeting given for the Polk County Medical Society and Woman's Auxiliary on December 11 at Perrys in Siren. Following a short business meeting a social hour was held.

RACINE

A dinner dance was given by the Racine County Medical Society on December 10th at the Racine Country Club. During the evening *Dr. Louis J. Kurten* was installed as president of the group. Other officers named are: *Drs. J. W. Postorino*, vice-president; *W. H. Bennett*, president-elect; *W. H. Williamson*, secretary; and *C. W. Christenson*, treasurer.

ROCK

The Rock County Medical Society elected officers for 1959 at its first joint dinner meeting with the Woman's Auxiliary October 28th at the Hotel Hilton, Beloit. Elected were:

J. C. Springberg, President
Marshall Purdy, President-elect
Robert Chancey, Secretary–treasurer

Drs. Roland Evenson and *Everett Reinardy* are the new members of the Board of Trustees.

Two University of Wisconsin professors from the Department of Pediatrics gave the program. Dr. Nathan Smith, spoke on "Nutritional Anemia of Childhood," and Dr. William Reiquam chose "Erythroblastosis Fetalis" as the subject of his lecture.

SAUK

"Treatment of Peripheral Vascular Disease" was the title of a speech delivered by *Dr. John T. Phelan*, Madison, at the November 11th meeting of the Sauk County Medical Society. The members met at Herman's Restaurant in Baraboo.

(continued)

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On December 9th the members of the county society heard *Dr. Henry M. Suckle*, a Madison neurosurgeon, talk on the diagnosis and treatment of congenital neurological lesions.

The main topic of business was the annual election of officers. The roster of officers includes: *Drs. Gibbs Zauft*, president; *J. A. Tibbitts*, president-elect; *J. J. Rouse*, secretary; *C. R. Pearson*, delegate; *E. V. Stadel*, alternate delegate; *Thomas Walsh*, members of the board of censors for three years; and *Milton Trautmann*, delegate to the Charitable, Educational and Scientific Foundation of the State Medical Society.

SHAWANO

The Shawano County Medical Society had a dinner meeting at the Shawano Municipal Hospital December 17. Dr. Robert A. Songe of Wausau spoke to the members on the subject of radium.

SHEBOYGAN

On December 16 the Sheboygan County Medical Society held its annual election of officers. They are:

President—*Robert A. Wood*
Vice-President—*Paul P. Bassewitz*
Secretary-treasurer—*Robert M. Senty*
Delegate—*Paul B. Mason*
Alternate Delegate—*Fred A. Nause*

TREMPEALEAU–JACKSON–BUFFALO

Drs. Roland Evenson and *Everett Reinardy* are Trempealeau–Jackson–Buffalo County Medical Society following the results of the elections held at a meeting on November 25 in Independence. He was also named alternate delegate. The remaining slate of officers chosen are: *Drs. John Marks*, president-elect; *John H. Noble*, secretary-treasurer; *B. C. Dockendorf*, delegate; *Robert Krohn* and *M. O. Bachhuber*, board of censors; and *O. M. Schneider*, public relations committee.

Final action was also taken on amending the constitution to comply with the Council Recommendation #3 of September 28, 1958.

WALWORTH

The Walworth County Medical Society met December 11 at the Colonial Hotel in Delavan to elect *Dr. W. C. Woods* as president, *Dr. Richard Rogers* as vice-president, and *Dr. Harlan Levin* as secretary.

A speech was delivered on "Bleeding Disorders" by E. D. Schilling.

WASHINGTON–OZAUKEE

The Washington–Ozaukee County Medical Society has announced that again this year they will offer a total of $200 in cash awards to high school stu-

(continued)

MEDICAL STAFF
OWEN OTTO, M. D.
Medical Director
EUGENE FRANK, M. D.
WILLIAM C. JANSSEN, M. D.
LOREN J. DRISCOLL, M. D.
JOSEF A. KINDWALL, M. D.
Consultant
LEROY A. WAUCK, Ph. D.
Clinical Psychologist

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dents in the two-county area. The contest is in conjunction with the 1959 AAPS Essay Contest sponsored by the Association of American Physicians and Surgeons Freedom Programs, Inc.

At a meeting of the society held on November 20 at the Republican Hotel in Kewaskum, *Dr. Paul Hausmann*, Milwaukee, presented a lecture on chest conditions seen in his practice. The talk was illustrated with x-ray films.

During the business session *Drs. H. J. Katz, V. V. Quandt*, and *R. H. Dorr* were elected as president, president-elect, and secretary–treasurer, respectively.

WINNEBAGO

The American Legion Clubhouse was the meeting site for the Winnebago County Medical Society smorgasbord dinner on December 11. Chairman of the department of surgery at Marquette University, Dr. Edwin Ellison, spoke to the organization on "Recent Advances in the Treatment of Hemorrhagic Shock."

On January 8 the members met at Menasha Hotel for their regular monthly dinner meeting. Preceding a business meeting, a film entitled, "M.D. International", was shown.

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Wisconsin Chapter, American College of Chest Physicians

The Chapter held its annual fall dinner meeting at the Milwaukee Athletic Club on November 19, 1958. Members and their guests participated in an open floor discussion of the scientific paper, "The Clinical Application of Pulmonary Function Studies," presented by *Dr. Walter Thiede.*

Among the specific applications of pulmonary function tests were the assistance in early diagnosis, a guide to the prognosis of patients with persistent respiratory tract disease, an appraisal of the patient's pulmonary reserve prior to major surgical procedures as well as measuring the success of therapy in those patients having chronic disabling pulmonary disease. Additional discussion concerned its application to industrial medicine as a screening measure prior to employment in those industries having known occupational inhalant exposures but also as a means of appraising such pulmonary disability as may arise from an occupational exposure to a pulmonary irritant.

The membership was informed of the election of *Dr. Mischa J. Lustok* of Milwaukee to the Board of Governors of the American College of Chest Physicians.

The Wisconsin Chapter officers for the 1958–1959 year are *Dr. Ross C. Kory*, president; *Dr. Leon H. Hirsh*, vice president; and *Dr. Raymond R. Watson*, secretary–treasurer.

The spring meeting of the Wisconsin Chapter will introduce the rotating Round Table Forum on cardio pulmonary diseases.

Wisconsin Psychiatric Association

The first annual scientific meeting of the Wisconsin Psychiatric Association, district branch of American Psychiatric Association, was held November 7 and 8, 1958, in cooperation with the University of Wisconsin Medical School, Department of Psychiatry, at Wisconsin Center Building, Madison.

Distinguished guests who participated in the program included: *Dr. Peter Eichman*, Assistant Professor of Neurology, UW Medical School; Dr. Francis Forster, Professor and Chairman, Department of Neurology, UW Medical School; *Dr. Saul Pollack*, Assistant Clinical Professor of Psychiatry, Marquette University School of Medicine; and Dr. Philip F. D. Seitz, Institute for Psychoanalysis, Chicago, Illinois.

Association members who were program participants are: *Drs. William Lewis*, Associate Clinical Professor of Psychiatry, UW Medical School; *Albert Lorenz*, Psychiatrist, Eau Claire; *Williams Lyons*, Psychoanalyst, Madison; George J. Martin, Psychoanalyst, Milwaukee; *Henry A. Peters*, Associate Professor of Neurology, UW Medical School, Robert Roessler, Associate Professor and Chairman, Department of Psychiatry, UW Medical School; *Max Smith*, Assistant Clinical Professor of Psychiatry, UW Medical School; *Eugene Turrell*, Professor and Chairman, Department of Psychiatry, Marquette University School of Medicine; and *Gilbert B. Tybring*, Assistant Clinical Professor of Psychiatry, UW Medical School.

Titles of subjects were: "Anxiety of Attaining a Goal," "Some Considerations of Etiology in Psychosomatic Disorders," "Stubbornness in Psychotherapy," "Metabolic Aspects of Epilepsy, Delirium Tremens, and Various Organic Brain Syndromes," "Some Relationships between Psychological and Physiological Variables, Some Experimental Results," "In the Guise of Functional Illness," and "Parental Behavior as Pathogenesis."

1958 officers of the Association are: Dr. Max Smith, president; Dr. Leonard J. Ganser, president-elect; Dr. Robert Roessler, past president; Dr. Gilbert B. Tybring, 301 Troy Drive, Madison, secretary; and Harold N. Lubing, treasurer.

Milwaukee Academy of Medicine

Dr. Alvin J. Ingram, Department of Orthopedic Surgery, University of Tennessee College of Medicine was guest speaker at the 935th meeting of the Milwaukee Academy of Medicine on November 18 at the University Club of Milwaukee. His subject was, "Athletic Injuries—Recognition and Treatment."

At the December 16 meeting of the Academy Dr. Arnold S. Relman, Associate Professor of Medicine, Boston University School of Medicine, and Physician in Charge, Renal and Metabolic Clinic, Robert D. Evans Memorial Hospital, was the guest lecturer and his subject was, "The Pyelonephritis Syndrome."

Wisconsin Society of Plastic Surgery

Drs. F. D. Bernard and *Gordon Davenport*, both of Madison, attended in Milwaukee the organizational meeting and founding of the Wisconsin Society of Plastic Surgery. Doctor Bernard was elected to the new society's board of directors.

Madison Eye, Ear, Nose and Throat Society

The current list of officers for the Madison Eye, Ear, Nose and Throat Society was announced recently. The three Madison physicians comprising the board are: *Benjamin Brindley*, president; *Mathew Davis*, vice-president; and *John Scott*, Secretary–treasurer.

(continued)

Physicians whose names are printed in italic are members of the Society.

SPECIALTY SOCIETIES (continued)

Milwaukee Oto-Ophthalmic Society

"Anesthesia Problems in Ophthalmology and Otolaryngology" was the subject chosen by Dr. Max S. Sadove for a talk delivered at the December 23rd meeting of the Milwaukee Oto-Ophthalmic Society held at the University Club of Milwaukee. Doctor Sadove is head of the Anesthesia Division at the University of Illinois Research and Educational Hospitals, Chicago.

Milwaukee Urological Society

The members of the Milwaukee Urological Society, at a meeting on November 17th, heard Dr. James Price of Madison discuss the etiological agents of carcinoma of the bladder. At this meeting the following officers were elected for the year 1959:

President—*John D. Silbar*
Secretary–Treasurer—*John W. Kearns*

Wisconsin Society of Obstetrics and Gynecology

The fall meeting of the Wisconsin Society of Obstetrics and Gynecology was held at the Elks Club in Eau Claire on October 25th. The one-day scientific program offered the following lectures:

"Bacteriologic Study of the Postpartum Patient," by *Dr. Harold Conlon*, Eau Claire.
"Epidural Block Anesthesia for Caesarean Section," by *Dr. Robert O. Bjurstrom*, Eau Claire.
"Coronary Heart Disease Complicating Pregnancy," by *Dr. William Madden*, Racine.
"Unusual Complications Requiring Caesarean Section," by *Dr. Howard Gass*, Milwaukee.
"Hamartoma," by Dr. Lee Stevenson, Detroit, Michigan.
"Releasin: Its Use in Normal Obstetrics," by *Dr. Raymond Swann*, Madison.

(continued)

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SPECIALTY SOCIETIES (continued)

"Carcinoma of the Cervix Part I," by Dr. William Kiekhofer, Madison.

"Carcinoma of the Cervix Part II," by *Dr. Alwin Schultz*, Madison.

"Case Report of a Pregnancy complicated by L.E.," by Dr. Henry Waldron, Milwaukee.

"Conservative Surgery for Ectopic Pregnancy" and film of successfully treated Abdominal Pregnancy with a living infant, by Dr. William Stromme, Minneapolis, Minnesota.

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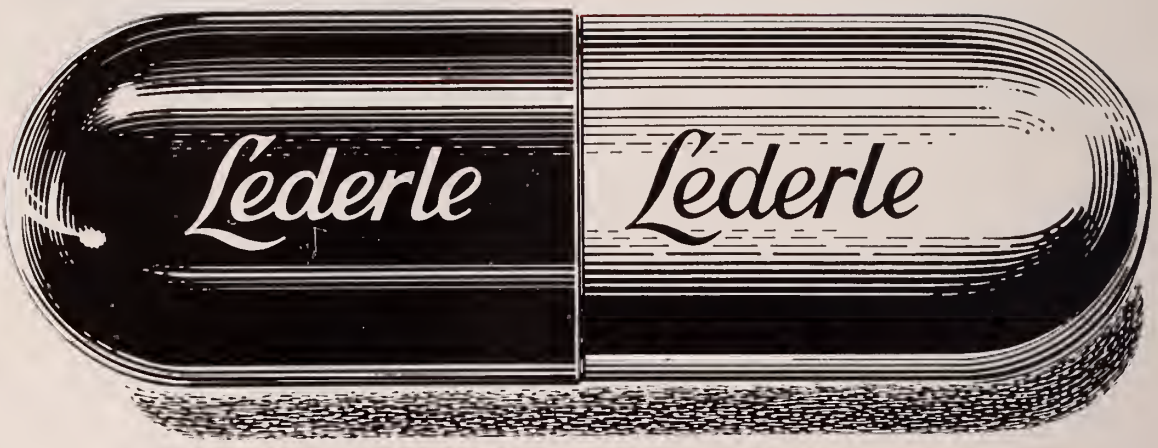

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News of Wisconsin Physicians

Doctor Nichols Addresses Lions Club

Dr. George Nichols of Appleton addressed the Appleton Lions Club recently on "What's New in Medicine." Some of the areas of medicine which he cited and which were presently receiving considerable emphasis were heart surgery, hypertension, arthritis, virus disorders and the uses of radio isotopes.

Doctor Simonson to La Crosse

Dr. S. W. Simonson is now affiliated with the Gundersen Clinic and La Crosse Lutheran Hospital at La Crosse in general practice. Prior to coming to La Crosse, he graduated from the University of Minnesota and was in private practice in Dallas, Wisconsin, until World War II. During the war he was stationed at various army hospitals in the States and in the Central and South Pacific. After his return to the States he served a year in Alaska during the building of the Alcan highway. Following his discharge he resumed private practice at Whitehall with the MacCornack Clinic.

Appointments to Cancer Conference

Wisconsin physicians appointed as state health representatives to the Regional Cancer Conference to be held at the Shoreland Hotel, Chicago, on February 25 and 26 are: *Carl N. Neupert*, State Health Officer, Madison, *P. B. Blanchard*, Cedarburg, *A. L. Van Duser*, Madison, and *Carlton Wirthwein*, Milwaukee. The appointments were approved by Dr. Arthur B. Price, Regional Medical Director of the Chicago Office of the U. S. Public Health Service.

Similar conferences have been held in a few other areas. The purpose is given as that of identifying objectives and measures common to practicing physicians and public health workers in cancer control. Nationally known members of such organizations as the American Cancer Society, the American College of Surgeons, the American College of Pathologists, the American College of Radiology and the A.M.A. have been invited. Program plans include presentations in the fields of clinical cancer, epidemiology and professional education. Discussion periods including group techniques are anticipated.

Doctor Solberg Builds Office in Elroy

Dr. Marvin Solberg, who recently moved from Viola to Elroy, is planning a building which will include offices for himself and a dentist, who also moved to Elroy recently.

Doctor Solberg went to Elroy last summer to take over the practice of *Dr. R. L. Demke* who moved to Illinois.

Physicians whose names are printed in italic are members of the Society.

Green Bay Hospital Elects Officers

Dr. Eugene Brusky has succeeded *Dr. Bernard Kulkoski* as Chief of Staff of St. Mary's Hospital, Green Bay. *Dr. Richard Jensen* was reelected vice president and *Dr. Kenneth Mickle* was again chosen as secretary–treasurer. Included on the hospital's executive committee are *Drs. Louis Milson, A. J. McCarey, Robert Schmidt* and *Clarence Rothe.*

Doctor Gargas Locates in Wausau

Dr. Bruce L. Gargas is now associated with *Dr. John V. Flannery* in the practice of medicine in Wausau.

Doctor Gargas moved to that city after being located in Sioux Falls, South Dakota, for the past five years. He obtained his medical education at Northwestern University and at various hospitals in the Chicago area. His first practice was set up at Providence, Rhode Island. He is certified by the American Board of Surgeons for general surgery.

Doctor Smejkal Speaks

The Manitowoc Industrial Safety Council's November problem clinic heard Dr. *Walter F. Smejkal* lecture on "Accidents and Diseases That are the Worst Offenders in Disabling our Industrial Workers." He said, "Accidents are the fourth leading killer in the country today ranked next to heart attacks, cancer and strokes in that order. Every accident has a direct cause many of which can be attributed to negligence on the part of the individual worker, or unsafe working conditions. He stressed that physical and mental disorders, strain and fatigue cause reduction of efficiency in the worker, which contributes to accidents.

Doctor Smejkal is a surgeon at the Manitowoc Clinic.

Burlington Clinic Has New Doctor

A native of Randolph, Dr. Donald Werner, has been affiliated with the Burlington Clinic since November 1. Doctor Werner came to Burlington following discharge from military service.

He was graduated from the University of Wisconsin Medical School, interned at St. Joseph's Hospital, Marshfield, and served a pediatric residency for three months at Wisconsin General Hospital, Madison, prior to entering the U. S. Army in September, 1956.

Melrose Has New Clinic

A new clinic has been built in Melrose by the Krohn Clinic and Hospital of Black River Falls. The 28 by 37-foot building is constructed of brick veneer and consists of a large waiting room, three consultation rooms, an office, laboratory, x-ray and utility rooms. A doctor visits the clinic three half-days a week to service the needs of the village.

(continued)

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1. Wright, W. T., Jr.; Pokorny, C., and Foster, T. L.: Kansas M. Soc. *57*:410, 1956. 2. Gilchrist, A. R.: Brit. M. J. *2*:1011 (Nov. 3), 1956. 3. Terman, L. A.: Illinois M. J. *3*:67, 1957.

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Chippewa Falls Hospital Names Staff Officers

In choosing the officers of the medical staff of St. Joseph's Hospital, Chippewa Falls, the physicians elected *Dr. Frank Sazama* as president, Dr. *C. T. Clauson* as vice-president, and *Dr. Merne Asplund* as secretary. These nominations were made in November.

Doctor Callahan Moves Office

Office facilities are now provided in the new addition to the home of *Dr. H. T. Callahan*, Spencer. The new section has a reception room, inner office, examination room, and lavatory.

Doctor Moon Honored at Baraboo

Dr. John Moon was honored in November with a farewell testimonial dinner by over 250 Baraboo friends and business associates. After 30 years of practice in Baraboo, Doctor Moon left in November to make his home at Mesa, Arizona, where his son, Dr. William Moon, and family are residing, and to join his wife who had gone there earlier in the year.

At the dinner Doctor Moon was presented with a plaque which read: *Testimonial of appreciation extended to Dr. John F. Moon, for services rendered the City of Baraboo, Wisconsin, and its people 1927–1958. With esteem and affection because of his personal qualities. Best wishes that he and his family may enjoy many years of health and happiness.*

Doctor Moon plans to resume his practice at Mesa where his son is also a physician.

Doctor Blekking Honored in Sheboygan

Residents of Sheboygan in November helped Dr. J. H. Blekking observe his 96th birthday and the couple's 25th wedding anniversary with cards, cakes, flowers and several parties. Doctor Blekking retired from the active practice of medicine when he was 71 years of age after 36 years of service. Doctor Blekking taught school for 12 years before starting his career in medicine. He had prepared for his career at Physicians and Surgeons Medical College in Milwaukee and began his practice in 1897 in Milwaukee.

Wisconsin Physicians Elected

At the twenty-third annual meeting of the membership of the Mississippi Valley Medical Society at Chicago, September 26, 1958, and the annual business meeting of the directors at Minneapolis, December 1, the following Wisconsin physicians were elected as officers and directors for 1959:

Dr. Wallace Marshall, Watertown, vice president for Wisconsin.

Dr. *Walter C. Roth*, Racine, *Dr. Leslie W. Tasche*, Sheboygan, and *Dr. Jack A. Klieger*, Milwaukee, directors.

Dr. Gunnar Gundersen, La Crosse, honorary member.

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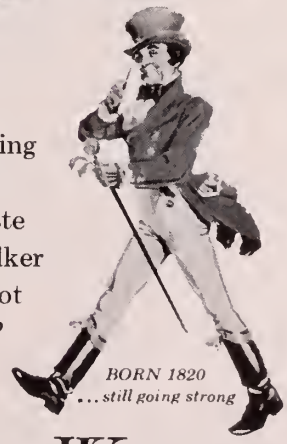

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The twenty-fourth annual meeting will be held at the Hotel Chase, St. Louis, September 29, 30, October 1, immediately preceding the American Medical Writers' Association meeting there October 2, 3.

THIRD AND TWELFTH DISTRICTS

Doctor Jackson Guest Speaker

Dr. Arnold S. Jackson, Madison, was a guest speaker at the Southeastern Regional Meeting of the United States Section, International College of Surgeons, in Miami Beach, Florida, January 4–7.

Residency in Surgery for Doctor McGrath

Dr. David J. McGrath is taking a residency in surgery at University Hospitals, Madison. He was graduated from the University of Wisconsin Medical School and interned at Los Angeles County General Hospital, Los Angeles, California. He has served one year of military duty.

Milwaukee Doctor's Portrait

A portrait of *Dr. Francis D. Murphy,* Milwaukee, was unveiled during a program dedicating the library of the Milwaukee County General Hospital. Doctor Murphy is director emeritus of medicine at the hospital.

Doctor Bamforth's Paper Chosen

A paper by *Dr. Betty Jane Bamforth* of the Anesthesiology Department of the University of Wisconsin was one of 20 papers chosen for presentation at the scientific meeting of the American Society of Anesthesiologists in the late fall. The paper entitled, "Fluorinated Hydrocarbons, a Blind Study", was co-authored by *Drs. K. L. Siebecker, J. E. Steinhaus* and *O. S. Orth.*

Cudahy Gets New Doctor

The Fine–Lando Clinic, Cudahy, has added Dr. Edward Orman to its staff. A native of the area, Doctor Orman graduated from the University of Wisconsin Medical School in 1957 and interned one year at Mt. Sinai Hospital, Milwaukee. He served in the U.S. Army from 1946 to 1949 before attending college.

Doctor Orth Speaks in Brazil

Dr. O. S. Orth of the U.W. Medical School was invited to be the guest speaker in Recife, Brazil, at the Brazilian Congress of Anesthesiology in November. While in Brazil he visited various societies in Rio de Janeiro and Sao Paulo and met with former members of the University of Wisconsin Medical School.

(continued)

Appointed to Committee

Dr. D. Murray Angevine was appointed recently by the National Research Council to serve on an Advisory Committee on the Skeletal System. He had served a term previously on the Committee on Pathology.

Doctor Forster Heads Tour

Dr. Francis M. Forster of the University of Wisconsin Medical School, headed a 30-day tour of Russian scientific institutions and a study of neurological services in the Soviet Union. Five other physicians accompanied Doctor Forster on this trip which was sponsored by the Public Health Services National Institute of Neurological Diseases and Blindness.

New Director of Preventive Medicine

Dr. Alfred S. Evans is Director of the Division of Preventive Medicine and Associate Professor of Preventive Medicine and Medical Microbiology at the University of Wisconsin. Doctor Evans was graduated from the University of Buffalo and interned at University Hospitals in Pittsburgh. He took his postgraduate work at Buffalo General and Goldwater Memorial Hospital in Internal Medicine. He has had four years of military service.

Doctor Hare Joins Jackson Clinic

Dr. J. Donald Hare has joined the Jackson Clinic as a specialist in pediatrics and pediatric cardiology. Following his graduation from Queen's University Medical School in Ontario, he interned at Victoria Hospital in London, Ontario, and did postgraduate work at Children's Hospital, London, Ontario, and at the University of Iowa.

Doctor Ellis Taking Residency

Dr. John C. Ellis, Jr., is now taking a residency in obstetrics and gynecology at University Hospitals in Madison. He was graduated from the University of Wisconsin Medical School and interned at the University of Texas Medical Branch Hospital in Galveston.

Correction!

In the November issue it was erroneously stated that *Dr. Ray Piaskoski*, Milwaukee, held the position of Chief of the Physical Medicine and Rehabilitation Service at the Veterans Administration Hospital in Wood. Doctor Piaskoski called to the Journal's attention that he is now a part-time consultant to the Veterans Hospital, and that since April of 1958 *Dr. Paul A. Dudenhoefer* has been Chief of the Physical and Rehabilitation Service at Wood. Doctor Piaskoski is also Director of Physical Medicine and Rehabilitation Services at St. Joseph, St. Francis and Deaconess Hospitals, Milwaukee.

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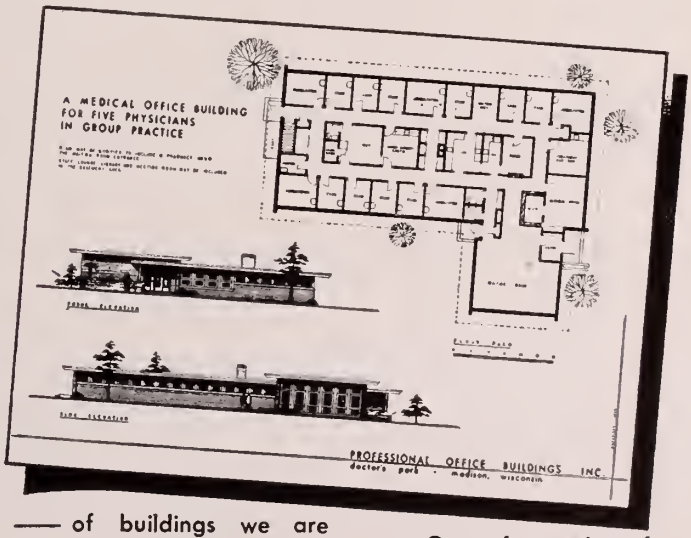

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SPONTIN IN SERIOUS

A Special Report from Abbott to the Medical Profession on a Year's Clinical Experience with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem — and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

Abbott

What's New at the Medical Schools

Artificial Heart Valve Developed at U.W.

Doctors Richard Botham, Cesar Castillo, *George Rowe, Wm. P. Young, Charles Crumpton* and George Maxwell head a research team of six physicians at the University of Wisconsin who have been experimenting for over a year with methods to correct malfunctions of the mitral valve in the heart. While surgery has sometimes aided in the problem of mitral stenosis, for many others, the only hope is still a response to certain drugs.

With the valuable assistance of Professor Ronald Daggett of the Mechanical Engineering Department, a circular object was devised which has six reinforced spokes and two nylon flaps that open and close with slight pressures and the entire mechanism is encased in a soft sponge.

For the present, experimental work will be done on dogs and while this research holds out new hope for persons having valvular heart conditions, it will probably require several more years before it can be accepted for use on human beings.

Complete Rehabilitation Center for Milwaukee

Construction of a complete rehabilitation center within the Milwaukee County General Hospital is announced by John W. Rankin, director of the Milwaukee County Institutions and Departments. The facility will include all physical restoration, vocational evaluation, psychological and social services, as well as an associated sheltered workshop.

Applications for key positions in the rehabilitation center are being accepted as it is anticipated the center will open in the summer of 1959.

The center was made possible by grants from the federal and state Vocational Rehabilitation departments. Through the Milwaukee County institutions and departments it will be affiliated with the Marquette University School of Medicine, which plans to use it as a teaching and training center for medical students, physicians and other specialists in rehabilitation and physical medicine. *Dr. Robert W. Boyle*, director of physical medicine, will be in charge of the facility.

Course in History of Medicine

A course in the History of Medicine will be included in the second semester curriculum at the University of Wisconsin Medical Center with the arrival of Dr. Gernot B. Rath, of Bonn University, Germany. Doctor Rath studied medicine at the Universities of Marburg, Hamburg, Berlin and Bonn. He obtained an M.D. degree at Bonn in 1948, and then became interested in the history of epidemics, anatomy in the Middle Ages and medical writing in the 16th and 17th centuries.

Discuss Trends in Hospital Administration

Wisconsin University Hospitals was host to the semi-annual meeting of the University Hospital Executive Council Meetings, held in November. Ray Amberg, President of the American Hospital Association and Director of Minnesota University Hospital, joined representatives of the eight hospital members in a discussion of recent trends in the administration of university hospitals.

Committee on Long-Range Planning

The Executive Committee, with a desire to review existing programs and anticipate future needs at the University of Wisconsin Medical School, set up a Committee on Long-Range Planning to arrange a program for the Medical School for the next five years. Members of this new committee are:

Robert E. Parks, Chairman	L. E. Hokin
John Rankin, Secretary	J. J. Lalich
Francis M. Forster	Charles Lobeck
Joseph Gale	A. A. Siebens
E. S. Gordon	R. R. Vevle
Duard Walker	*O. A. Mortensen* (ex officio)

New Associate Professor at Marquette

James G. Hilton, Ph.D., 35, an Associate Professor of Pharmacology at the University of Mississippi Medical Center, has accepted an appointment as an Associate Professor of Pharmacology at Marquette University School of Medicine. The appointment, announced by Rev. E. J. Drummond, S.J., Academic Vice-president of the University, is effective January 1, 1959. Doctor Hilton becomes the fifth full-time faculty appointment in the Department of Pharmacology.

Doctor Hilton, after four years of service as a Lieutenant in the United States Navy (1942–46), received his B.S. degree from Virginia Polytechnic Institute in 1947 and his M.S. and Ph.D. degrees from the University of Tennessee in 1952 and 1954, respectively. In 1952–53 he was a Teaching Fellow in Pharmacology at the University of Tennessee, and since September, 1953, has taught at the University of Mississippi, first as an Assistant Professor of Pharmacology (1953–55) and later as an Associate Professor of Pharmacology (1955 to date).

Doctor Hilton is a member of the American Society for Pharmacology and Experimental Therapeutics, the American Physiology Society, the American Federation for Clinical Research, the Society for Experimental Biology & Medicine, the American Association for the Advancement of Science, the American Heart Association, and the New York Academy of Science. He is also a member of Sigma Xi.

(continued)

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Eben J. Carey Memorial Lecture

Dr. Claude S. Beck, Professor of Cardiovascular Surgery at Western Reserve University and University Hospitals, will be the guest lecturer at the twelfth annual Eben J. Carey Memorial Lecture of Phi Delta Epsilon, national medical fraternity, on March 31 at 4:30 P.M. in the Marquette University School of Medicine Auditorium. Dr. Beck will speak on "Coronary Artery Disease: Physiology and Operation," and he will also show color movies. Alan E. Lewis, junior medical student, is in charge of program arrangements.

Annual Preceptors Meeting

Physicians from each of the state's 15 Preceptorships, which play a significant role in the senior year program, held their annual meeting in November at the Medical Center of the University of Wisconsin Medical School. Research reports and discussions on the part Preceptorships play in the educational curriculum were the main features of the two-day session. These meetings were climaxed by dinner at the State Medical Society and attendance at the Wisconsin–Minnesota football game. The Preceptorship has been in continuous effect at the University of Wisconsin since 1927.

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Medical Meetings - Postgraduate Courses

A.M.A. Medicolegal Meetings

Three regional medicolegal conferences will be held by the A.M.A. in March and April in Washington, D. C., Cleveland, and Salt Lake City. The law division of the A.M.A. is working in cooperation with state and local medical societies to put on these conferences since the feeling is that medicine and law must work together so frequently that open discussions of mutual problems seem imperative.

American College of Surgeons

More than 3,500 surgeons, nurses, and related medical personnel from throughout the country are expected to attend a comprehensive, four-day Sectional Meeting of the American College of Surgeons in St. Louis, March 9 through 12, 1959. Headquarters will be the Kiel Auditorium, with many sessions scheduled also in leading St. Louis hospitals.

Two Wisconsin physicians will appear on the program. Dr. Erwin E. Grossmann will participate on Wednesday, March 11, in the symposium, "Ophthalmic Surgery of Trauma," and his subject is, "First Aid by General Surgeon and Industrial Nurse: Prudent Limits." Dr. Walter P. Blount will participate in two symposiums on Thursday, March 12. He will discuss "Treatment of Fractures in Children" in the symposium on "Fractures." "Scoliosis: Its Conservative and Surgical Management" will be discussed by him in the symposium on "Low Back Pain." Both physicians are from Milwaukee.

This four-day meeting, like the annual Clinical Congress, is designed to inform the medical profession at large about developments in surgery, and to focus attention on newer ways of handling problems encountered in daily practice. The program will include hospital clinics, panel discussions, symposia, scientific papers, technical exhibits, medical motion pictures and cine clinics in general surgery and in the specialties of thoracic surgery, urology, gynecology and obstetrics, ophthalmic surgery and orthopedic surgery.

The joint nurses program, now an annual feature of this four-day meeting, will include discussions on comprehensive care of the patient who has successfully undergone pelvic evisceration, open technique in the management of burns, congenital heart disease, and other problems. Special films, and tours and demonstrations at local hospitals will add interest and importance to this program.

Hotel reservation forms and other information about the meeting may be obtained by writing the Department of Organization and Assembly, American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

Chicago Medical Society

"Keeping up" with current medical developments is one of the most pressing problems of the practicing physician. Medical meetings are one of the main sources of new information. The Annual Clinical Conference of the Chicago Medical Society will be held at the Palmer House, March 2, 3, 4 and 5, 1959.

A faculty of the outstanding speakers will present 33 half-hour lectures on subjects of interest to the general practitioner and the specialist. Panels on timely topics, a clinical-pathologic conference, and medical color telecasts will be presented. Teaching demonstration and instructional courses will be presented to small groups to encourage a close relation between the instructor and the physician. Scientific and technical exhibits have been carefully selected.

The instruction courses will be an innovation of the Conference. The four courses cover "Problems in Surgery" to be held from 9:00 to 10:00 A. M. each day; "Problems in Medicine" which will be held daily from 11:00 to 12:00 o'clock noon; "Problems in Obstetrics and Gynecology" to be held daily between 1:30 and 2:30 P. M.; and "Problems in Allergy" which will be held between 4:00 and 5:00 P. M. daily. The instruction courses will be limited to 20 physicians per class and registration must be made in advance. The fee for each course is $5.00.

For further information write: Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois.

Wisconsin Public Health Meeting

The tenth annual meeting of the Wisconsin Association for Public Health, affiliate of the American Public Health Association, Inc., is scheduled for May 25 to 27 at Green Lake, Wisconsin, on the grounds of the American Baptist Assembly. May 25 is reserved for the Wisconsin Public Health Council.

Annual Meeting Wisconsin Heart Ass'n.

The Wisconsin Heart Association's 1959 annual meeting will be held Saturday, June 13, in Milwaukee. Plans for the one-day meeting include both scientific and lay sessions. The meeting will be held in Milwaukee County General Hospital.

Other Meetings

National Health Council, Palmer House, Chicago, March 17–19. Mr. Philip E. Ryan, 1790 Broadway, New York 19, Executive Director.

New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, March 2–5. Maurice E. St. Martin, 1430 Tulane Ave., New Orleans 12, Secretary.

(continued)

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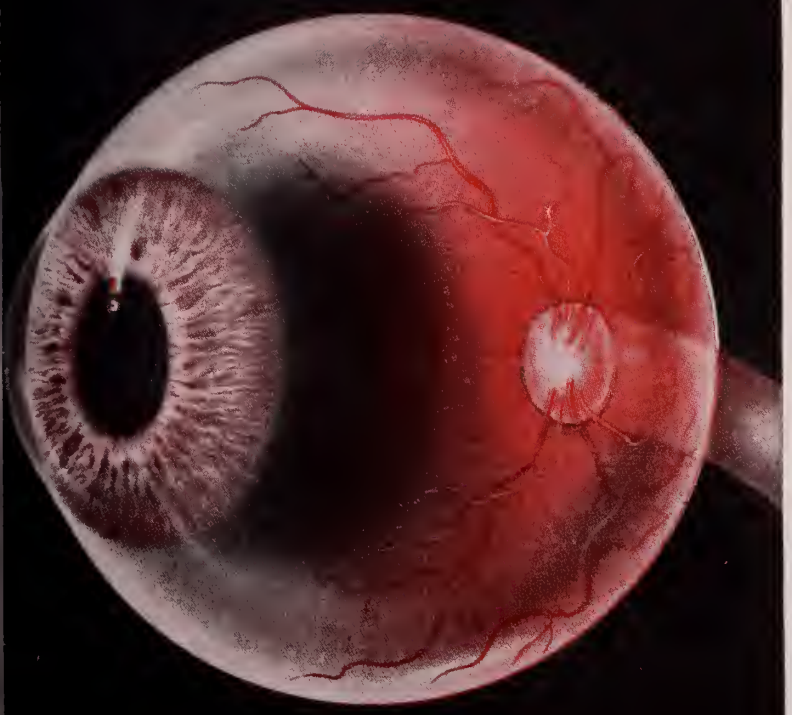

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Reinhardt, D. J.:
Delaware State Med. J. 30:1, January 1958.

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Bunn, W. H., Jr.:
Ohio State Med. J. 54:1168, September 1958.

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Herrmann, G. R., Hejtmancik, M. R., Graham, R. N. and Marburger, R. C.:
Texas State J. Med. 54:639, September 1958.

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UW Postgraduate Course

The University of Wisconsin Medical School will have a postgraduate course on, "Hematology and Hypertension," at the University Hospitals March 19–21, at Madison.

Guest lecturers in addition to faculty members will be: Scott Swisher, M.D., Associate Professor of Medicine, University of Rochester, School of Medicine, Rochester, N. Y., and George E. Wakerlin, M.D., Medical Director, American Heart Association, New York City.

Subjects for Thursday, March 19, include: Acute Leukemia, Diagnosis of Chronic Leukemia and Polycythemia Vera, Survey of Hemostatic Disorders, Laboratory Techniques in the Diagnosis of Hemostatic Disorders, and Thrombocytopenia.

Friday, March 20: Pathologic Physiology of Anemia, Iron Deficiency, Diagnostic Techniques in Hemolytic and Deficiency Anemias, Genetic Factors in Hypertension and the Natural Course of the Disease, Physical Factors Determining Arterial Blood Pressure, Constitutional and Environmental Factors as They Pertain to Circulatory Dynamics in Man, and Are Malignant Hypertension and Benign Hypertension Different Diseases?

Saturday, March 21: Pathogenesis of Essential Hypertension, Clinical and Laboratory Evaluation of the Hypertensive Patient, General Considerations on the Pharmacology of Hypertension–Etiological and Therapeutic Aspects, Hypertension Associated with Toxemia of Pregnancy, Effect of Therapy on Prognosis in Patients with Hypertension.

For further information write: Robert C. Parkin, M.D., Coordinator of Graduate Medical Education, 418 N. Randall Avenue, Madison 6, Wisconsin.

University of Minnesota Courses

Medical continuation courses to be presented at the Center for Continuation Study, University of Minnesota, are:

March 2–4: Pediatrics for General Physicians.

March 14: Trauma for General Physicians.

March 16–18: Internal Medicine for Internists.

March 30—April 3: Basic Concepts of Water and Electrolyte Balance for General Physicians.

April 2–4: Emergency Surgery for General Physicians.

April 6–8: Radiology for General Physicians.

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

North Shore Hospital Lecture

The sixth lecture in the Ninth Annual North Shore Hospital Lecture Series on "Emotional Forces in the Family" will be held at the hospital, 225 Sheridan Road, in Winnetka, Illinois, on Wednesday, March 4 at 8:00 P.M. "The Impact of Aging in the Family" will be discussed by D. Griffith McKerracher, M.D., Professor of Psychiatry, University of Saskatschewan; Chief, Department of Psychiatry, University Hospital.

The Commission on Education of the American Academy of General Practice has approved these lectures for Category II credit. All physicians and allied professional personnel are welcome to attend.

Mayo Clinical Reviews

Staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research will present again this year a three-day program of lectures and discussions on problems of current interest in general medicine and surgery at Rochester, Minnesota, on April 13, 14, 15, 1959.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

Drugs of Choice, 1958–1959. Edited by Walter Modell, M.D., Associate Professor of Pharmacology, Cornell University Medical College, New York City. The C. V. Mosby Co., St. Louis, Mo. 1958. 931 pages. Price $12.75.

This book is a commendable effort by Doctor Modell to gather authoritative evaluations of drugs which are being employed at the present time in the practice of medicine. The opinions of thirty-seven authorities are expressed in thirty-five general areas of therapeutics. An attempt has been made to indicate the drug of choice for each clinical condition considered. As Doctor Modell has stated in the preface, it is hoped that this book will provide in one place unbiased, authoritative, and definitive information bearing on the problem.

The chapters, for the most part, are divided into sections, each of which presents the clinical conditions for which therapy is being considered, the pharmacotherapeutics of the drugs, and the basis for recommending one or another agent. Occasionally more than one drug is recommended. Each section is concluded with the author's expression of the needs and the possible future developments in the area. A drug index at the end of each chapter provides a list of the agents commonly employed for the clinical conditions which have been considered, some of the proprietary names and the manufacturers, and the available dosage forms.

The major shortcoming of this publication is recognized by the editor, *i.e.* the lack of sufficient data to form a definite opinion on the usefulness of an agent or the selection of one drug in preference to another. It is hoped that the editor's implication of a regular revision will be realized.—*F. E. Shideman, M.D.*

The Eternal Search. By Richard Mathison, a magazine writer and a newspaper reporter, now on the staff of the Los Angeles Times. G. P. Putnam's Sons, 210 Madison Ave., New York City. 1958. 381 pages. Price $5.95.

These tales of myths, stupidities, cruelties and quackeries of our past are offered by the author in the hope that they may "warn us against the dangers of self satisfaction and dogmatism." Indeed they should; many of them continue to this day. Much wide reading and "hundreds of clippings" have gone into this "haphazard" collection of man's "Eternal Search" for well-being. The term "search" seems to me too fine a word to apply to a collection that does not strive to show a thread of progression. But possibly not; earnest curiosity has had at least some part in these strivings. The author tends to stress the morbid, the salacious, the unusual, deadly potions, the extremes rather than the "golden mean" that might have provided a continuing thread. The chapter headings including also the quotations, bits of wisdom from sources far and wide, are among the best parts of the work. 381 pages, including a general bibliography and a good index.—*Paul F. Clark, M.D.*

* * *

Essentials of Clinical Neuroanatomy and Neurophysiology. By John T. Manter, Ph.D., M.D., F. A. Davis Company, 1914–16 Cherry Street, Philadelphia 3, Pa.

The author has fulfilled in this monogragh his objective, providing a short but comprehensive survey of the human central nervous system. This title, "Essentials of Clinical Neuroanatomy and Neurophysiology," appears ambiguous since: (1) new facets of the neurological sciences are unfolding constantly, (2) the integration of structural (anatomic) with functional (physiologic) relationships are often not clear enough to formulate clinically a focal diagnosis.

However, the sequence of the chapter division permits the reader to review and to relearn neurology easily, especially since clear diagrams and/or drawings facilitate comprehension and localization of the subject matter. Chapters 8, 13, 14 and 21 are especially instructive.

Doctor Manter's monograph is the neurologic handbook for physicians in the practice of medicine. It can be recommended to students of medicine and psychology.

One page with specific reference to the literature (*i.e.*, Chapter 3 or 20) will enrich this practical booklet. A firmer cover is recommended.—*Hans H. Reese.*

* * *

NEW BOOKS

A Bibliography of Internal Medicine; Communicable Diseases. By Arthur L. Bloomfield, M.D., Professor Emeritus of Medicine, Stanford University School of Medicine, The University of Chicago Press, Chicago. 1958. 560 pages. Price $10.00.

Therapeutic Uses of Adhesive Tape. Johnson & Johnson, New Brunswick, New Jersey. 1958. 130 pages.

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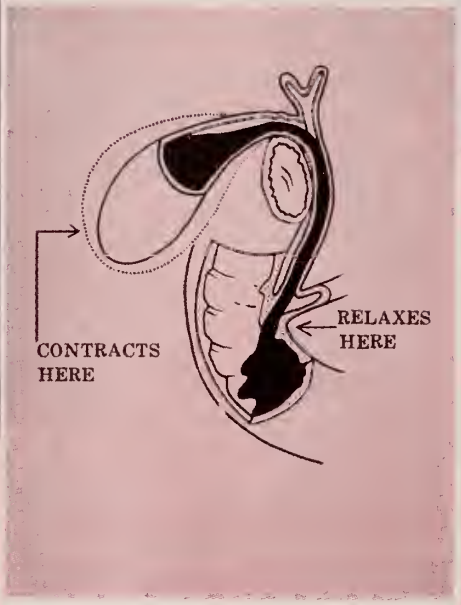

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1. Herland, A. L., Lowenstein, A.: Quart. Rev. Surg. Obst. & Gynec. 14:196 (Dec.) 1957

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O. F. Guenther, Campbellsport, to 721 Baldwin Avenue, Oshkosh.
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Andrew Boyd, Jr., ** Milwaukee, to Station Hospital, U. S. N. Submarine Base, New London, Connecticut.
A. T. Holbrook, Milwaukee, to 535 Edgewater Drive, Dunedin, Florida.
P. P. Foderick, Plum City, to Hallock, Minnesota.
V. R. Vanstane, Edgerton, to 1402 Lake View Avenue, Madison.
R. S. Vivian, Beloit, to 390–2nd Avenue, South, Naples, Florida.
R. L. MacCornack, Jr., Whitehall, to 1044–17th Avenue North, South St. Paul, Minnesota.
R. E. Bolinski, Columbus, Ohio, to 1204 Francis Place, Richmond Heights, Missouri.
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(continued)

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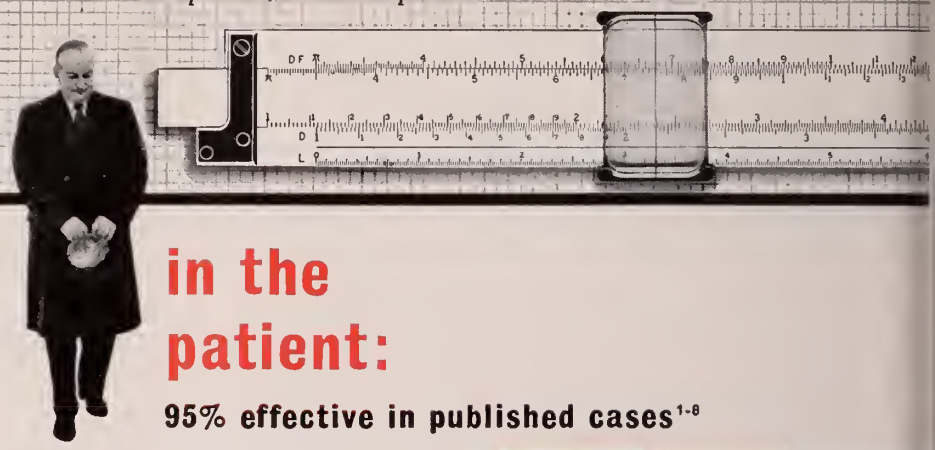
* *designed for superior control of common Gram-positive infections*



in the patient:

95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	558	448	80	30
Respiratory infections	258	208	31	19
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	–	6
Otitis media	31	29	2	–
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	230	191	38	1
Infected wounds, incisions and lacerations	41	33	8	–
Abscesses	51	43	8	–
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	–
Pyoderma	19	19	–	–
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	–
Genitourinary infections	28	19	3	6
Acute pyelitis and cystitis	10	8	2	–
Urethritis with gonorrhea or cystitis	8	8	–	–
Pyelonephritis	4	1	–	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	–	–
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	4

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L. O. Simenstad, Osceola, 1960

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J. C. Griffith, Milwaukee, 1959

William D. Stovall, Madison, 1959

Alternates

John M. Bell, Marinette, 1960

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R. E. Galasinski, Milwaukee, 1959

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W., Ashland	C. A. Grand 520 W. Second, Ashland	
Barron–Washburn–Sawyer–Burnett	D. G. MacMillan 13. S. Main Rice Lake	H. M. Templeton Barron	Second Tuesday 7:30 p.m.
Brown	Donel Sullivan 305 E. Walnut Green Bay	Frank Urban 305 E. Walnut, Green Bay	Second Thursday°
Calumet	J. M. Guthrie 302 Cleveland, Brillion	J. W. Knauf Chilton	
Chippewa	B. J. Haines Cadott	R. L. Hendrickson 12 Third, Cornell	Second Tuesday
Clark	T. N. Thompson, Jr. Neillsville	H. M. Braswell, Jr. Owen	
Columbia–Marquette–Adams	C. F. Broderick Wisconsin Dells	T. S. Westcott Pardeeville	Every Third Month 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	L. E. Holmgren 30 S. Henry St., Madison	A. P. Schoenenberger 122 W. Washington, Madison	Second Tuesday Sept. through June
Dodge	G. G. Drescher 106½ Front Beaver Dam	Andrew Vrahec 302 N. Spring Beaver Dam	Last Thursday°
Door–Kewaunee	J. F. March 413 4th, Algoma	A. S. Lanier 3rd & Ellis, Kewaunee	
Douglas	R. T. Anderson 1507 Tower, Superior	L. R. Rosin 2231 E. Fifth, Superior	First Wednesday°° Hotel Superior
Eau Claire–Dunn–Pepin	D. M. Willison 314 E. Grand, Eau Claire	K. E. Walter 131 S. Barstow, Eau Claire	Last Monday
Fond du Lac	E. W. Vetter 80 Sheboygan Fond du Lac	R. W. Schroeder 39 S. Main Fond du Lac	Fourth Thursday°
Forest	O. S. Tenley Waheno	D. V. Moffet Crandon	
Grant	H. L. Doeringsfeld Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.

°° Except July and August. ° Except June, July and August.

(Continued on next page)

List of Officers and Scheduled Meetings of County Medical Societies *(Continued)*

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Green	L. G. Kindschi 1770 13th, Monroe	J. A. Frantz Monroe Clinic, Monroe	
Green Lake–Waushara	G. G. Mueller Princeton	J. C. Koch Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	J. C. Russell 38 S. Water, W. Ft. Atkinson	H. W. Aufderhaar 38 S. Water Ft. Atkinson	Third Thursday*
Juneau	V. M. Griffin Hess Clinic Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	John B. Pearson 624 57th Street Kenosha	Mr. L. F. Jost, Ex. Sec. Box 669, Kenosha	First Thursday* Elks Club
La Crosse	J. R. Richter 203 Fifth Ave. S., La Crosse	P. C. Dietz 1020 Market St., La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane 123 E. Ann, Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	J. E. Garritty Antigo	First Monday
Lincoln	R. G. Baker Tomahawk	H. G. Adams 110½ W. Wisconsin Tomahawk	
Manitowoc	J. W. Steckbauer Suite 304, Savings Bank Building, Manitowoc	D. A. Kuljis 1606 Washington Two Rivers	Last Thursday
Marathon	J. V. Flannery 808 Third, Wausau	T. C. Burr, Jr. Fifth and Jefferson Wausau	
Marinette–Florence	Clarence H. Boren 1510 Main, Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	J. S. Devitt 944 N. Jackson Milwaukee	E. M. End 7608 W. State, Wauwatosa Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main, Oconto	C. E. Siefert Oconto Falls	
Oneida–Vilas	W. K. Simmons 1020 Kabel, Rhinelander	Marvin Wright 1020 Kabel, Rhinelander	Monthly
Outagamie	H. T. Gross 103 W. College Appleton	W. A. Dafoe 103 W. College Appleton	Third Thursday* Elks Club
Pierce–St. Croix	P. S. Haskins River Falls	P. H. Gutzler River Falls	Third Tuesday
Polk	M. E. Wegner St. Croix Falls	L. J. Weller Osceola	Third Thursday 7:00 p.m.
Portage	W. C. Sheehan 755 Strongs, Stevens Point	W. A. Gramowski 319½ Main, Stevens Point	
Price–Taylor	W. W. Meyer 410 S. Second, Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	L. J. Kurten 810 Main Racine	W. H. Williamson 1101 Grand, Racine	Third Thursday
Richland	George Parke 323 S. Central Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	J. C. Springberg 405 E. Grand Beloit	R. L. Chancey 1146 Grant Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	G. W. Zauft 590 Fourth Prairie du Sac	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	L. W. Peterson Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	R. A. Wood 1011 N. Eighth Sheboygan	R. M. Senty 1011 N. Eighth, Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	E. P. Rohde Galesville	J. H. Noble 912 Harrison Black River Falls	Fourth Tuesday
Vernon	H. E. Oppert 318 S. Main, Viroqua	R. A. Starr Viroqua	Last Wednesday
Walworth	W. C. Woods 607 Walworth Delavan	H. M. Levin Delavan	Second Thursday*
Washington–Ozaukee	H. J. Katz 11 Center Cedarburg	R. H. Dorr Belgium	Fourth Thursday
Waukesha	James V. Bolger, Jr. 102 E. Main, Waukesha	Philip Wilkinson 618 W. La Belle, Oconomowoc	First Wednesday
Waupaca	Owen Larson Clintonville	H. S. Caskey Clintonville	
Winnebago	P. S. Emrich 456 Mt. Vernon, Oshkosh	G. B. Hildebrand 59 Racine, Menasha	First Thursday
Wood	W. L. Nelson 480 E. Grand Wisconsin Rapids	J. R. Heersma 650 S. Central, Marshfield	Four times a year

* Except June, July and August.

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Chairman Emeritus
R. G. Arveson_____Frederic
Chairman Emeritus

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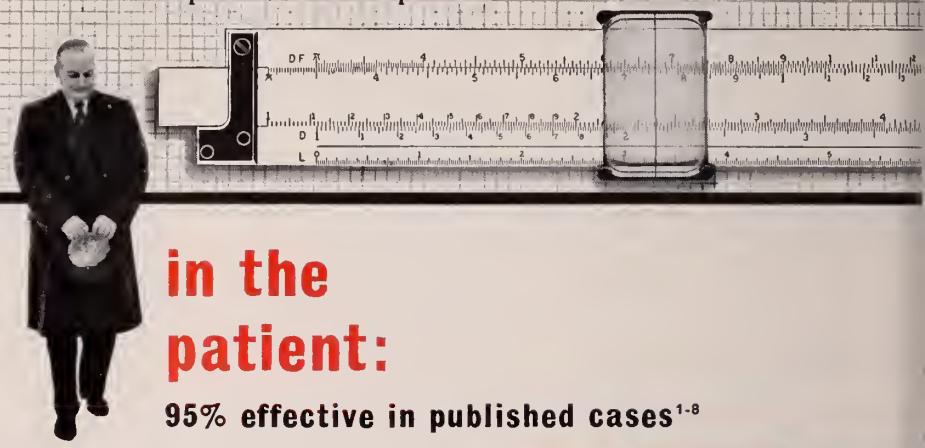

in the patient:

95% effective in published cases[1-8]

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Infectious asthma	44	38	—	6
Otitis media	31	29	2	—
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	**191**	**38**	**1**
Infected wounds, incisions and lacerations	41	33	8	—
Abscesses	51	43	8	—
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	—
Pyoderma	19	19	—	—
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	—
Genitourinary infections	**28**	**19**	**3**	**6**
Acute pyelitis and cystitis	10	8	2	—
Urethritis with gonorrhea or cystitis	8	8	—	—
Pyelonephritis	4	1	—	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	—	—
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	**42**	**30**	**8**	**4**

County Society Proceedings

Brown

An Oshkosh physician, *Dr. E. A. Strakosch*, addressed the members of the Brown County Medical Society at their January 8th meeting held at the Elks Club in Green Bay. He spoke on "The Treatment of Acne Vulgaris." Also appearing on the program was *Dr. H. J. Kief*, Sixth District Councilor, who presented a report on the December 13 and 14 meeting of the Council.

During the business session a motion was made and passed that physicians are to be called in alphabetical order for Red Cross Bloodmobile Service. Those failing to serve will be censored according to the rules adopted previously.

Columbia–Marquette–Adams

On December 9 the Columbia–Marquette–Adams County Medical Society met at the Country Inn in Columbus. The business for the evening consisted of the annual election of officers. Those chosen were: *Drs. C. F. Broderick*, Wisconsin Dells, president; *R. F. Poser*, Columbus, president-elect; and *T. S. Westcott*, Pardeeville, secretary–treasurer.

Dane

The Dane County Medical Society held its February 10th meeting at the Bardeen Laboratories on the University of Wisconsin campus. Three University of Wisconsin physicians, Dr. Frank Forster, Chairman of the Department of Neurology; Dr. Harry Waisman, Professor of Pediatrics; and Dr. Arthur Siebens, Associate Professor of Pediatrics and Physiology, addressed the group.

Eau Claire–Dunn–Pepin

Thirty-five members of the Eau Claire–Dunn–Pepin County Medical Society met at the Eau Claire Hotel on January 26 for a business session. During the meeting general policy measures were discussed and the following officers for 1959 were nominated:

President—*J. W. Lowe*
Vice–President—*A. W. Hilker*
Secretary–treasurer—*T. D. Moberg*
Censor—*Julius Blom*
Delegates—*O. G. Moland* and *I. L. Blose*
Alternates—*A. A. Drescher* and D. R. Griffith

Jefferson

"Pediatric Orthopedic Problems of Lower Extremity" was the topic chosen by *Dr. Bruce Brewer* of Milwaukee when he addressed the Jefferson County Medical Society on January 15 at the Jefferson Country Club.

Following the lecture, a business meeting was held, during which time *Dr. H. N. Hunsader* was elected to the County Relief Committee, *Drs. E. J. Netzow* and *E. E. Burzynski* were appointed to the Public Health Committee, and *Drs. D. P. Epperson* and *R. P. Welbourne* were named to the Cancer Committee.

Kenosha

On January 8th the principal speaker of the Kenosha County Medical Society was *Dr. Abraham Melamed*, radiologist at Deaconess Hospital, Milwaukee. He spoke on radiology and the benefits of chest x-rays on admission to a hospital.

During the business session *Dr. J. B. Pearson* assumed the duties of president. A motion was passed to have Mr. Lee Jost continue as executive secretary of the society and *Dr. William Swift* to be the president–elect for the year beginning January 1960. *Dr. Harry Schwartz* and *Dr. Richard Ashley* were appointed delegate and alternate, respectively.

La Crosse

At the January monthly meeting of the La Crosse County Medical Society the members heard several speakers on the subject of the Red Cross blood program. Persons contributing to the topic were: Dr. R. F. Barnes of St. Louis, midwest area director of the blood program; Mr. L. J. Peterson, business manager of the Badger Regional Blood Center at Madison; *Dr. Merle Hamel*, medical director of the Badger center; and Mrs. Alf Gundersen, director of public relations of the La Crosse County Red Cross Chapter's blood program.

Outagamie

The Outagamie County Medical Society held its regular monthly meeting on January 15. Guest speaker for the meeting was *Dr. Helen A. Dickie*, Madison, whose subject covered the problems of chronic diffuse, pulmonary disease and differential diagnosis.

Richland

Dr. George Crandall was elected president of the Richland County Medical Society at a meeting held December 4 at the Park Hotel in Richland Center. *Dr. Dayton Hinke* was elected vice-president and *Dr. L. M. Pippin* was reelected secretary–treasurer. *Dr. D. J. Taft* was named as delegate with *Dr. R. E. Housner* chosen as alternate. *Dr. Jack Spear* was named censor.

The library of the Richland Hospital, Richland Center, was the site of the group's January 15th meeting. Guest lecturer for the evening was *Dr. Anthony Curreri*, of the University of Wisconsin Medical School, who presented a paper on "Lesions of the Breast."

(continued)

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Sauk

Under the direction of the Sauk County Medical Society, the Sauk County Health Committee is offering polio immunizations to all children under 21 years of age. This drive in February, March, and April is again being offered by the society in an effort to immunize all children in the county. The vaccine is being given free to all children whose parents are financially unable to pay for the service.

Shawano

Dr. D. S. Arvold was elected president of the Shawano County Medical Society at the monthly meeting January 21 at the Shawano Hospital. Named vice-president was *Dr. W. J. VonRuden*, with *Dr. A. J. Sebesta* elected secretary–treasurer. Another item of business which the members discussed and agreed upon was that a fourth shot of the Salk polio vaccine should be given two years following the third dose.

During the scientific session, *Dr. R. C. Cantwell* spoke on the use and over-usage of vitamins.

Vernon

Members, wives and guests of the Vernon County Medical Society heard *Dr. Gunnar Gundersen*, La Crosse, president of the American Medical Association, give a short talk following a dinner at the Vernon Memorial Hospital, December 24. In his speech Doctor Gundersen related some of his memories of his early days in the medical profession when he travelled on occasion to Vernon County. He prophesied that the "Golden Age of medicine will continue" and told of the doctors' interest in extended old age, not only from the medicine standpoint but also for legislation.

Walworth

A joint meeting of the Walworth County Medical Society and the Walworth County Bar Association was held on January 8 at the Arizona Inn in Delavan. "The Interprofessional Code" was discussed by *Dr. George Thomas*, Janesville, and Mr. Norman Skogstad, a Milwaukee attorney.

Winnebago

"Recent Advances in the Treatment of Hemorrhagic Shock" was the title of *Dr. Edwin Ellison's* lecture at the December 11th meeting of the Winnebago County Medical Society held at the American Legion Clubhouse in Oshkosh. Doctor Ellison is the newly appointed chairman of the department of surgery at Marquette University School of Medicine.

Members later elected *Dr. George P. Schwei*, president and delegate, *Dr. S. R. Beatty*, president-elect; *Dr. George Hildebrand*, secretary; *Drs. D. M. Regan* and *Warren Hahn*, alternate delegates; and *Dr. E. A. Strakosch*, delegate.

(continued)

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Facts about

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WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

Health Care for Our Senior Citizens

Prepayment of medical care for the elderly has long been a matter of urgent and continuing concern to the medical profession and its Blue Shield Plans. Within the past year, however, this problem has been made something of a political issue through the introduction of such legislation as the Forand Bill, which, if adopted, might radically affect the future of the entire voluntary health care movement in America.

What are the facts concerning Blue Shield coverage of senior citizens? What has the medical profession accomplished, through Blue Shield, to meet this challenge?

The answers to these questions will be of immediate interest as a New Congress meets—a Congress in which social welfare programs are certain to be accorded a high priority.

Some of these answers, as reported recently to A.M.A.'s Council on Medical Service by the national association of Blue Shield Plans, are truly encouraging.

In 1951, among a total Blue Shield enrollment of 21 million persons, nearly a million, or a little less than 5%, were over 65 years of age. Six years later, in 1957, among the total of 40 million persons enrolled, 2½ million, or 6½%, were over age 65. Thus, in these 6 years, the number of Blue Shield members over 65 increased 170%, while total Blue Shield enrollment increased only about 85%.

Attention was called also to the fact that of the total number of people past 65 who have medical–surgical insurance coverage, about two-thirds are covered by Blue Shield.

Of all the people in the U. S., it is estimated currently that about 15 million are over 65 years old, and are not cared for by an established institution or agency. This represents approximately 8% of the total population. Thus, Blue Shield's ratio of 6½% over age 65 is reasonably related even now to the ratio of the total population in that group—and rapidly approaching parity with it.

Blue Shield has always sought to serve medicine's inescapable responsibility to the *whole* community. It was until recently almost an exclusively Blue Shield feature that any member on retirement, or on leaving an insured group, could retain his coverage by "conversion" to a "direct-pay" basis. Few Plans impose any age limits on initial group enrollment, and an increasing number of Plans are accepting nongroup members regardless of age.

Blue Shield is aware of medicine's responsibility to our senior citizens, and is prepared to follow the guidance and leadership of the profession in helping it meet this challenge.

Wisconsin Physician's Service contracts for surgical–medical–hospital protection are available to individuals up to 70 years of age. The Commission on Medical Care Plans of the State Medical Society is now developing a special program for those over 65 who have modest incomes. It is scheduled to begin on a trial basis within a few months.

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Wood

The Wood County Medical Society met December 4 at Wilbern's in Wisconsin Rapids. Twenty-one members were present to hear Dr. B. S. Salibi, Marshfield, talk on the levels of consciousness and its relation to neurosurgery and general patient management.

On January 22 the society met at the Hickory Pit in Marshfield, at which time *Dr. R. E. Garrison* of Wisconsin Rapids presented a paper on "Bloody Stools."

During the business meeting the following physicians were elected to office:

G. S. Custer, president
L. C. Pomainville, vice-president
J. R. Heersma, secretary–treasurer
R. W. Mason, delegate
E. C. Glenn, alternate

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John F. Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D
John R. Whitty, M. D.
Preston W. Thomas, M. D.

News from the Specialty Societies

Milwaukee Academy of Medicine

The annual dinner meeting of the Milwaukee Academy of Medicine was held Tuesday evening, January 20, at the University Club of Milwaukee. Claude E. Forkner, M.D., Professor of Clinical Medicine, Cornell University Medical College, was the guest speaker. His subject was, "American Medicine's Responsibility Overseas."

Doctor Forkner discussed the disadvantages of the United States' Four Point program. He stated that the program is mistrusted by the people of other countries because they suspect that it is a political maneuver to buy security rather than an expression of generosity. Doctor Forkner suggested that this may be remedied by the formation of a "foundation for international goodwill composed of people who know the world." This foundation would be used to distribute funds for international welfare work with money donated by the United States and existing foundations. He also proposed establishment of an international medical school in this country to be used by foreign students.

The 938th meeting of the Academy was held Tuesday, February 17, at the University Club of Milwaukee. Henry W. Brosin, M.D., was guest speaker for the Arthur Wilson Rogers Memorial Lecture. Doctor Brosin is Director and Chairman, Department of Psychiatry, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic. His subject was, "The Doctor-Patient Relationship and Communication Theory." Members of the Milwaukee Neuro-Psychiatric Society and their guests were invited to attend this dinner meeting.

Milwaukee Oto-Ophthalmic Society

Dr. Charles E. Iliff, Professor of Ophthalmology Johns Hopkins University Medical School, Baltimore, Maryland, was guest lecturer at the February meeting of the Milwaukee Oto-Ophthalmic Society which met February 24 at the University Club in Milwaukee. His subject was, "Advances in Arbital Surgery in the Past Ten Years."

Wisconsin Orthopedic Society

The annual state meeting of the Wisconsin Orthopedic Society was held in Wisconsin Dells during November. There were approximately 40 physicians in attendance. Among those named to office positions were two Green Bay doctors, *J. W. Nellen* as president and *J. E. Kaufman* as secretary–treasurer. Their chief functions will be planning the semi-annual meetings of the society.

Physicians whose names are printed in italics are members of the Society.

Wisconsin Radiological Society

Announcement has been made that the physicians listed below are the 1959 officers of the Wisconsin Radiological Society:

S. R. Beatty, Neenah—President
R. W. Byrne, Milwaukee—President-Elect
F. F. Golden, Madison—Secretary–Treasurer

Wisconsin Society of Pathologists

The next seminar meeting of the Wisconsin Society of Pathologists will be held on June 20 in Madison, (exact site to be determined). A morning session of papers on various aspects of clinical pathology, to be given by members of the society, will be followed in the afternoon by a seminar on "Surgical Pathology of the Intestinal Tract". This will be moderated by *Dr. E. A. Birge*, Milwaukee Hospital, Milwaukee, and Marquette University School of Medicine. A limited number of slide sets, at a cost of $10.00 per set, will be available. Anyone interested should write to *Dr. Robert S. Haukohl*, 561 N. 15th Street, Milwaukee.

The next business meeting of the Society will be held in Milwaukee during the annual meeting of the State Medical Society of Wisconsin on May 5–7. Dr. Oscar B. Hunter, Jr., of Washington, D. C., will address a joint meeting of the Wisconsin Society of Pathologists and the State Medical Society as one feature of the program.

Wisconsin Psychiatric Association

Forty-two psychiatrists from throughout the state attended the regular meeting of the Wisconsin Psychiatric Association held Friday evening, February 6, at the Cuba Club in Madison.

At this meeting a paper was presented by *Dr. Gilbert B. Tybring*, clinical director of Mendota State Hospital, and concerned a follow-up study on patients released from that hospital during 1956 and 1957 to continue on tranquilizing drug medication at home. The paper discussed particularly the various positive and negative roles played by the family, the patient, the local physician, and the hospital, with respect to the patient's continued adjustment.

A business meeting which followed revised policy and procedure for committee functioning and performance of business, and considered current state legislation pertaining to the field of mental health.

Wisconsin Urological Society

The Wisconsin Urological Society will meet at the Racine Hotel in Racine on Saturday, April 11. Dr. Frank Hinman, Jr., professor of urology at the University of California, will be the guest speaker. Local arrangements are in charge of *Dr. Frank Hilpert*, who is president of the Society.

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News of Wisconsin Physicians

Doctor Heinz Resumes Practice

A former Sheboygan practitioner, *Dr. Harold N. Heinz,* has returned to practice in that city after serving on the staff of the St. Croix Falls Clinic, St. Croix Falls, for the past year.

Doctor Heinz' past experiences include: a degree from Marquette University School of Medicine in 1946; six months at St. Luke's Hospital, Milwaukee; from 1948–1953 was industrial physician at the Kohler Company; and spent two years as a medical officer in the U.S. Air Force.

Plum City Gets Doctor

After being without the services of a physician since last August, the residents of Plum City welcomed Dr. Burt Erickson with an open house on the second day of his arrival in their city in early December.

An Idaho physician and surgeon, Doctor Erickson is a graduate of the University of Colorado Medical School. He interned at Albuquerque, New Mexico, and practiced for a short time at Caldwell, Idaho, before moving to Wisconsin.

Prior to receiving his medical education, Doctor Erickson served in the U.S. Air Force, received a master of science degree and taught zoology at the University of Denver.

Monroe Woman Physician in "Who's Who"

Green County's only woman doctor, Dr. Mary H. Frantz, an internist at The Monroe Clinic, has been included in the latest "Who's Who of American Women." Doctors Mary and *John A.*, her physician husband, came to practice in Monroe in 1955.

She received her medical degree from the University of Colorado in 1951 and interned at Denver General Hospital the following year. She has done postgraduate work in gynecology at the University of Utah and in general practice at the University of Wisconsin. The two physicians had a general practice at Montrose, Colorado, for two years. Doctor Mary practiced pediatrics at Columbia, Missouri, in 1954–55, three months of which were with the Student Health Clinic there.

Among her outside interests are her lectures in Red Cross first aid courses, music, camping, and five young daughters.

Baby Sitters Hear Doctor's Lecture

A pediatrician, Dr. Robert Gerth of Oshkosh, spoke to the Camp Fire Girls in October during the second session of the baby sitter's course sponsored by the Oshkosh fire department. In his talk, Doctor Gerth stressed some danger signals the sitter may detect in an ill child and pointed out several first-aid fundamentals important to the sitter.

Physicians whose names are printed in italics are members of the Society.

Appoint New Director at Sanatorium

Dr. A. A. Pleyte of Milwaukee has been named medical director of the Middle River Sanatorium, Hawthorne, and Douglas County General Hospital.

After 38 years of service, he had retired in January of 1958 as medical director of the Wisconsin Anti-Tuberculosis Association. In the past he has held the posts of president of the Wisconsin Trudeau Society, and president of the Mississippi Valley Trudeau Society. He received the 1958 Dearholt Medal at the annual meeting of the Mississippi Valley Conference on Tuberculosis at Dayton, Ohio, last October.

Sheboygan Hospital Appoints Officers

At the annual staff meeting of the doctors of the St. Nicholas Hospital, Sheboygan, *Dr. Henry Winsauer* was elected president for 1959. *Drs. Willard Huibregtse* and *F. P. Nause* were named vice-president and secretary, respectively.

Doctor Klutzow Opens Gillett Office

Dr. Fred W. Klutzow has moved to Gillett where he opened an office for the practice of medicine. Prior to coming to Gillett, Doctor Klutzow had practiced in Madison, Maine.

The doctor was born in the Dutch East Indies and served for five years in the Dutch Armed Forces during World War II. During three of these years he was a prisoner of war of the Japanese in Burma.

Following the war in 1946, he went to Holland to obtain his medical education. Graduating in 1951, he continued his training with a two-year postgraduate course and then came to the United States. He spent two additional years of studies in Massachusetts and Connecticut before going to Maine.

Hillsboro Doctor Returns

In December *Dr. L. L. Sanford* resumed his Hillsboro practice after spending the past several months as senior physician in chest at the U.S. Veterans Administration Chest Clinic in Pittsburgh, Pennsylvania. Doctor Sanford originally settled in Hillsboro in 1946.

New Stanley Clinic Open

In October the Stanley Clinic was completed for the practices of Drs. *A. W. Overgard* and *R. J. Mathwig.* The L-shaped building has two wings, 60x68 feet, and is constructed of brick and redwood. Besides a natural finished mahogany waiting room, there are fourteen rooms which include a pharmacy, examining rooms, emergency room, and a dark room. In the basement is a large storage room which can be converted easily into additional rooms if the need arises.

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said: Dr. Louis Brooks in a paper published Sept., Oct. issue, Diseases of the Colon and Rectum, Vol. 1, No. 5.

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WISCONSIN PHYSICIANS (continued)

Bloomer Doctor Gets New Clinic

In December the new quarters of *Dr. C. T. Clauson* of Bloomer were completed. The building, constructed of cement block and brick, measures approximately 32x42 feet.

Doctor Clauson graduated from medical school at the University of Wisconsin and has practiced in Bloomer for the past 28 years.

New Doctor Locates in Barron

A new physician, Dr. Ralph C. Whaley, formerly of Janesville, has joined *Dr. C. J. Strang* in his medical practice at Barron. Doctor Whaley is a graduate of the University of Wisconsin Medical School and has served an internship at Emanuel Hospital, Portland, Oregon. Prior to coming to Barron, Doctor Whaley spent two years in the U.S. Army, being stationed in Germany.

Doctor Oudenhoven Speaks

The Green Bay District Nurses Association heard *Dr. R. C. Oudenhoven*, Green Bay neurologist and neurosurgeon, speak at their December 10 meeting. In his talk entitled, "What the Nurse Should Know Regarding Brain Surgery and Diagnostic Procedures," he brought out the important relationship of the nurse to the surgeon in her observations of the vital sign and symptoms of the patient.

Menomonie Hospital Elects Officers

The Memorial Hospital, Menomonie, reelected Dr. *K. H. Neldner* as president of the medical staff for 1959. They also renamed *Drs. J. B. Tweeten*, vice-president, and *S. R. Lee*, secretary. The hospital staff is comprised of 14 members from Menomonie, Elmwood, Spring Valley, and Glenwood City.

Heads Brown County Cancer Group

It was recently announced that *Dr. John E. Dettmann* has been named president of the Brown County Cancer Crusade for the 1959 term. Doctor Dettmann is a general practitioner in Green Bay.

(continued)

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Medical Staff Heads Named

The Luther Hospital, Eau Claire, recently named new officers to the medical staff. The executive committee is composed of *Drs. S. B. Russell*, chief of staff; *D. M. Willison*, vice-chief of staff; *H. E. Thimke*, secretary–treasurer; *J. H. Wishart* and *G. E. Wahl.*

Those elected to the chairmanships of the various committees are: *Drs. D. E. Hoff, R. O. Bjurstrom, H. E. Sorenson, J. T. Gericke, H. J. Conlon, J. B. Dibble, R. R. Richards, W. O. Paulson, A. J. Klein, P. A. Midelfart, C. M. Ihle, T. D. Mobery, A. W. Hilker, R. C. Brown*, and *D. M. Willison.*

Doctor Liebenow Is Staff Chief

A Lake Mills physician, *Dr. E. A. Liebenow*, is the new president of the medical staff of St. Mary's Hospital, Watertown. Other officers of the staff are: *Dr. F. A. Wendt*, Johnson Creek, vice-president; and *Dr. John H. Becker*, Watertown, secretary–treasurer.

New Doctor in Prairie du Chien

Dr. James R. Wong opened a private practice of general medicine, surgery and obstetrics in Prairie du Chien on February 1. He was born in British Guinea, South America, and received his medical degree in 1951 from Loyola University. After completing a year of internship at Mary of St. Nazareth Hospital, Chicago, Illinois, he served a five-year residency in general surgery at West Suburban Hospital, Oak Park, Illinois, the last three years of which were spent in a preceptorship under a General Surgery Board Diplomate.

Doctor Novak at Madison General

Dr. Richard F. Novak has begun his residency in pathology at Madison General Hospital, Madison, where he recently completed his internship. He was graduated from the Stritch School of Medicine in Chicago.

Doctor Becker Has New Associate

Announcement was made recently that Dr. Westley R. Shaw is affiliated with *Dr. W. T. Becker* in the practice of surgery at Wausau. Doctor Shaw graduated from the University of Illinois Medical School and interned at Cook County Hospital, Chicago. He then spent three years at Queen's Hospital in Honolulu, Hawaii, in residency training. After the completion of his medical education, he was located at the Veterans Administration Hospital at Grand Junction, Colorado, for two years and was assistant chief of surgery and chief of thoracic surgery for 1½ years at the Veterans Administration Hospital, Dayton, Ohio. He is certified by the American Board of Surgery.

Doctor Murphy Moves to Arcadia

Dr. P. J. Murphy has located in Arcadia in association with *Dr. F. T. Weber*. He came to Arcadia from Calumet, Michigan, where he had practiced for the past 14 years.

Before entering the medical profession, Doctor Murphy received his M.A. degree from the University of Michigan and worked as a teaching assistant in physiology. He received his M.D. degree from that university, also, and interned at Rochester General Hospital, Rochester, New York. His postgraduate training includes two years of surgery at Rochester General Hospital, and surgery and gynecology at Cook County School of Postgraduate Studies in Chicago. During the war he was assigned to the Calumet area to protect the health of the copper miners and he remained there until the recent move.

New Radiologist in Marshfield

The Marshfield Clinic has added a new member to the staff, Dr. Mathew B. Lesser, who will practice in the radiology department of the Clinic. The addition of Doctor Lesser raises the number of physicians associated with the clinic staff to 35.

Doctor Lesser graduated from New York Medical College in 1951 and interned for one year at Rhode Island Hospital, Providence, and spent one year in an internal medicine residency at that hospital before entering the U. S. Air Force. Upon discharge, he returned to Providence for training in radiology, which he completed in 1957. He has been studying under a fellowship in radiation therapy and nuclear medicine at Queen's Hospital Center in Jamaica, New York, for the past year.

Marshfield Hospital Names Officers

Officers were named at the annual staff meeting of St. Joseph's Hospital, Marshfield, on January 15. Those chosen were: *Dr. J. L. Ousley;* chairman of the staff; *Dr. Raymond Hansen*, vice-chairman; and *Dr. James Manier*, secretary. *Drs. T. J. Rice, F. C. Kroeplin*, and *J. S. Vedder* were elected to the hospital's executive committee.

Doctor Bishop in Prairie du Sac

A native of Wisconsin, Dr. Paul Bishop, has joined *Dr. Gibbs Zauft* of Prairie du Sac in the practice of medicine. Doctor Bishop arrived in Wisconsin after practicing for the past eight years in Haynesville, Louisiana.

He is a graduate of the University of Wisconsin Medical School and also holds a degree in pharmacy from the University of Wisconsin.

Officers Elected at Lakeside Hospital

The medical staff of the Lakeside Methodist Hospital, Rice Lake, has elected *Dr. N. A. Eidsmoe* chief of staff. Other officers named were *Dr. D. G. MacMillan*, vice chief, and *Dr. L. R. Cotts*, secretary.

(continued)

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Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride .....250 mg.
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Panmycin (tetracycline) equivalent to tetracycline hydrochloride .....125 mg.
Albamycin (as novobiocin calcium)..62.5 mg.
Potassium metaphosphate ....100 mg.

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Panalba KM Granules
For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.

Pictured above, left to right, are: Dr. C. A. Richards, Dr. Irving E. Schiek, Sr., both of Rhinelander, who were recently honored for more than 50 years of service apiece by the Rhinelander Chamber of Commerce, and Mr. James R. Durfee, formerly chairman of the Wisconsin Public Service Commission and now chairman of the Civil Aeronautics Board, Washington. Mr. Durfee was the guest speaker at the banquet. (Photo courtesy of *Rhinelander News*)

Two Rhinelander Doctors Honored

Tribute was paid to two Rhinelander physicians, *Drs. C. A. Richards* and *I. E. Schiek, Sr.*, for more than 50 years of service apiece. A banquet was given in their honor at the 1958 dinner of the Chamber of Commerce held in December.

Doctor Hong Returns to Wild Rose

Having completed 15 months of special surgical training at the Veterans Administration Research Hospital in Chicago, Illinois, Dr. Roy Hong has returned to resume his practice in Wild Rose.

Doctor Hong first settled in Wild Rose in 1944, being associated with the Wild Rose Hospital until 1947 when he opened his own office. He enlisted in the U.S. Air Force in 1955 and returned in 1957. The doctor then practiced a short time before taking his additional training.

Doctor Baldwin at Texas Meeting

Dr. R. S. Baldwin, Marshfield, participated in a discussion at the Baylor University Medical School on February 5 and 6. The subject of the discussion was DBI (phenformin), a new treatment for diabetes in tablet form. Doctor Baldwin has been working with the new drug for six months. He reported his findings at the meeting. The meeting was sponsored by the Houston Society of Internal Medicine. Doctor Baldwin was one of 16 who gave reports on clinical trials of the drug, which is not yet generally available.

Doctor James Army Promotion

Headquarters of the XIV U. S. Army Corps Reserve recently announced the promotion of Lt. Col. *William D. James* to the grade of Colonel in the reserve unit of the medical corps. Doctor James is a general practitioner at Oconomowoc.

THIRD AND TWELFTH DISTRICTS

Doctor Dickie Attends Meeting

Dr. Helen A. Dickie was present at the February 1–6 meetings of the Veterans Administration Conference held in St. Louis, Missouri. Doctor Dickie is Professor of Medicine and Student Health at the University of Wisconsin.

Jackson Clinic Adds New Doctor

Dr. Gordon F. Schumacher, having recently completed a three-year residency in obstetrics and gynecology at the State University of Iowa, has been added to the staff of the Jackson Clinic, Madison. Doctor Schumacher is a 1954 graduate of Marquette University School of Medicine and has served an internship in Los Angeles, California. He is a junior fellow in the American College of Obstetricians and Gynecologists.

Doctor Middleton Renamed to VA Position

Dr. William S. Middleton, Dean of the University of Wisconsin Medical School from 1935 until 1955, has been reappointed for a four-year term as chief medical director of the department of medicine and surgery of the Veterans Administration at Washington, D. C. In accepting this second four-year term he continues in his work of governing the 172 Veterans Administration hospitals, throughout the nation.

Rotarians Hear Doctor Crumpton

Dr. Charles Crumpton addressed the Madison East Rotary club at its January 13 meeting. He is in charge of the medical aspects of the cardiovascular surgical team at Wisconsin General Hospital.

"Who's Who" Includes Doctor Kasten

The 31st edition of "Who's Who in America" has added the name of *Dr. H. E. Kasten*, Beloit urologist and dermatologist, to the list of the nation's outstanding persons.

Born in Wisconsin in 1888, Doctor Kasten graduated from the Rush Medical College in 1921. He came to Beloit in 1923 after practicing initially in Muncie, Indiana. He has taken postgraduate studies at the New York Polyclinic in 1929, and the University of Vienna in 1931 and 1954.

Active in many phases of medical and community affairs, Doctor Kasten has served as president of the State Line Scout council; was a member of the National council of Boy Scouts; was president of the Beloit City Council, has been director and executive committee member of Blue Shield of Wisconsin, is a diplomate of the American Board of Urology, is a fellow of the American College of Surgeons: World Medical Association, was president of the Mississippi Valley Medical Society, and is a past president of

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the State Medical Society of Wisconsin. He holds memberships in the Wisconsin and Chicago Urological Societies, North Central branch American Urological Association, American Urological Association, American Urological Society, and International College of Surgeons.

In Pediatrics at U. of W.

Beginning February 1, *Dr. Horace K. Tenney, III*, is an Assistant Professor of Pediatrics at the University of Wisconsin Medical School. Doctor Tenney, who has been a member of the clinical staff and has been in private practice in Madison, has taken the responsibility of the pediatric program offering medical care to the spouse and dependents of undergraduate students.

Doctor Tenney came to Madison in 1950 after completing a residency at Denver Children's Hospital. He graduated from Northwestern University Medical School in 1945 and interned at Newport Naval Hospital.

Doctor Hartlaub Lectures

Dr. Eugene Hartlaub chose the Christopher recording on "Sex Education Guide for Parents" to illustrate his talk presented to the Janesville Junior Woman's Club members and their husbands at a meeting held January 28. Doctor Hartlaub is a general practitioner associated with the Janesville Medical Center.

Stoughton Hospital Elects Officers

In December the medical staff of the Stoughton Hospital chose officers for the ensuing year. Among those named are: *Drs. R. J. Gray*, chief-of-staff; *A. T. Smedal*, vice-chief; and *F. M. Schammel*, secretary–treasurer.

Doctor Kay Honored

In January *Dr. Harry M. Kay* received a national citation from the Military Order of the World Wars. The plaque was presented to him in recognition of patriotic service in the interests of national security. Doctor Kay, a Madison physician, holds the rank of an Army Reserve major.

Doctor Samp Speaks

Recently *Dr. Robert Samp*, University of Wisconsin staff member, presented several talks. Among the groups to hear him were the Schenk School PTA, Madison, on "The Facts of Life About Cancer", the Fond du Lac Industrial Safety Council which he addressed on the subject of reducing problems, and the University of Wisconsin's Auxiliary to the Student American Medical Association for whom he discussed the medical student's wife's role presently and in the future.

Doctor Peckham Speaks

Dr. Ben Peckham, Chairman of the Department of Obstetrics and Gynecology, UW Medical School, Madison, participated in a postgraduate course at the University of Nebraska on January 15 and 16. On January 27 he spoke at Cedarburg on "Cancer Detection" under the auspices of the American Cancer Society.

On Allergy Program in Chicago

Two Milwaukee physicians took part in roundtable discussions during the fifteenth annual meeting of the American Academy of Allergy held in Chicago February 9–11 at the Morrison Hotel.

Dr. Howard J. Lee, assistant clinical professor of medicine at Marquette University School of Medicine, discussed "Treatment of Bronchial Asthma", while *Dr. Theodore L. Squier*, discussed "Allergic Diseases of the Blood."

Doctor Squier was also chairman of the scientific session for one afternoon. He is a past president of the Academy (1950).

The 1960 meeting has been scheduled for January 11, 12 and 13 at Hollywood-By-The-Sea, Florida; the 1961 meeting, February 6, 7 and 8 at Washington, D.C.

Doctor Orth to Anesthetists' Meeting

Dr. O. Sidney Orth, Chairman of the Department of Anesthesiology, UW Medical School, Madison, attended the annual meeting of the Association of University Anesthetists held recently in New York City.

Doctor Forster Elected to Office

Dr. Francis M. Forster, chairman of the department of neurology, UW Medical School, Madison, was elected vice-president of the American Board of Psychiatry and Neurology at its annual meeting.

Milwaukee Hospital Names Officers

St. Francis hospital in Milwaukee recently elected the following officers to its medical staff: *Dr. Edward J. O'Neill*, chief-of-staff; *Dr. Lawrence C. Sass*, vice-president; and *Dr. Joseph G. Halser*, secretary and treasurer. Named heads of departments are: Drs. *James R. O'Connell*, medicine; *Stanley E. Zawodny*, general practice; *Richard T. Flynn, Jr.*, obstetrics and gynecology; and *Thomas J. Pendergast*, surgery.

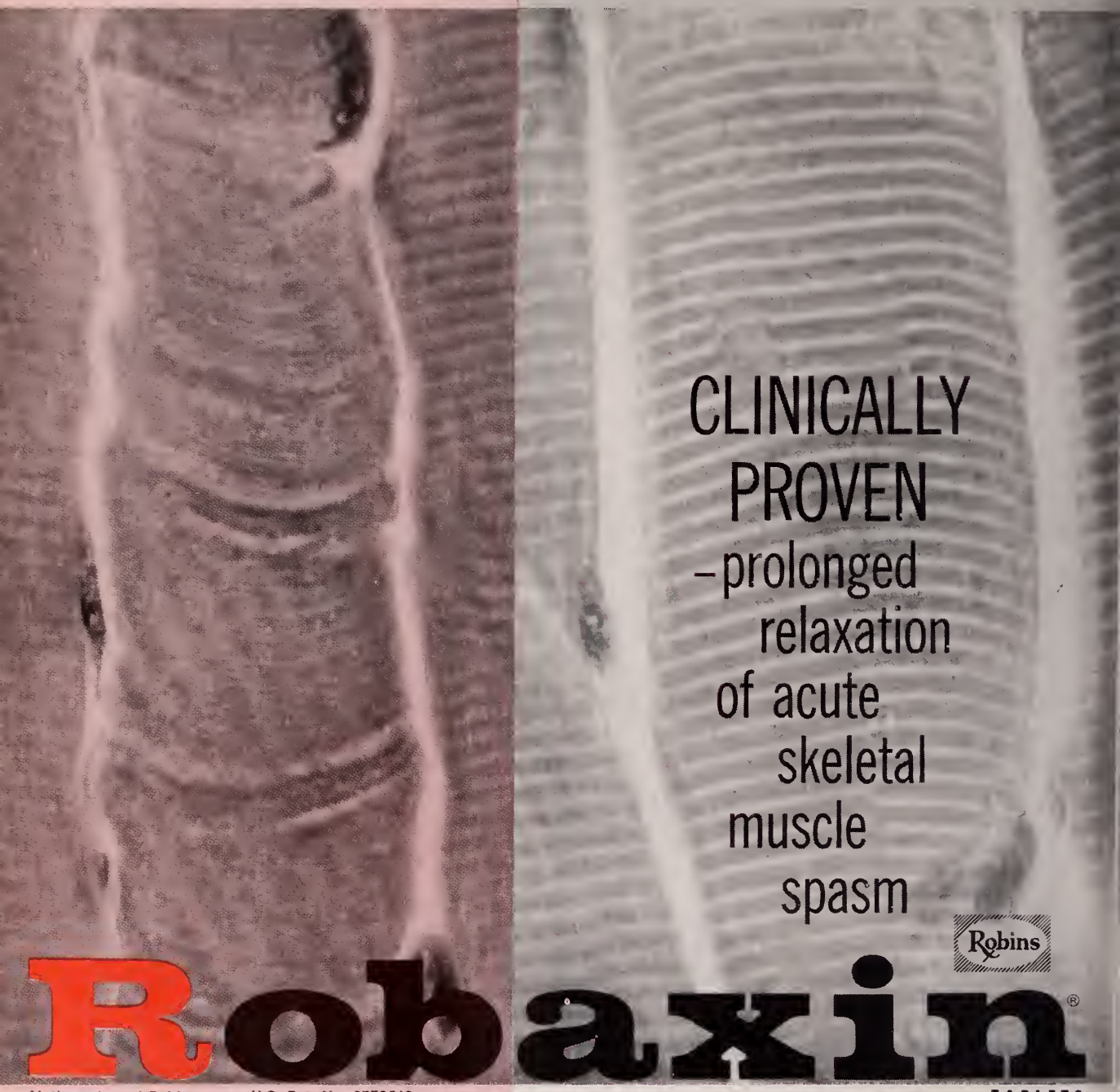
Doctors Elected at Madison General

Dr. Eugene Nordby was reelected chief of the medical staff of Madison General Hospital at a meeting held January 27. The remaining officers chosen were:

Theodore Nereim, M.D.—vice chief of staff
Norman Clausen, M.D.—secretary-treasurer
Royal Rotter, M.D.—chief of internal medicine
Russell Sinaiko, M.D.—chief of surgery
Richard Hennen, M.D.—chief of general practice
Gerald Kring, M.D.—chief of obstetrics and gynecology
Alex Iams, M.D.—chief of pediatrics

Fiber of skeletal muscle in spasm

Fiber of skeletal muscle relaxed *(photomicrographs)*



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TABLETS

Summary of six published clinical studies:

ROBAXIN BENEFICIAL IN 92.4% OF SKELETAL MUSCLE SPASM CASES

	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
Carpenter[1]	33	26	6	1	—
		"pronounced"			
Forsyth[2]	58	37	20	—	1
		"good"			
Lewis[3]	38	25	6	—	7
		"excellent"			
O'Doherty & Shields[4]	17	14	2	1	0
		"significant"			
Park[5]	30	27	—	2	1
		"gratifying"			
Plumb[6]	60	55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

- **Highly potent—and long acting.**[1,2,3]
- **Relatively free of adverse side effects.**[1,2,3,5,6]
- **In ordinary dosage, does not reduce muscle strength or reflex activity.**[1]

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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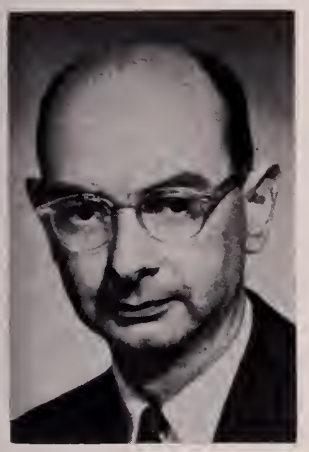
What's New at the Medical Schools

Doctor Evans Has New Appointment

Dr. Alfred S. Evans, who for the past six years has been Director of the Preventive Medicine Section of Student Health and Associate Professor of Medical Microbiology at the University of Wisconsin Medical Center, has recently been appointed Chairman of its newly established Department of Preventive Medicine and Director of the State Laboratory of Hygiene.



Doctor Evans

In an effort to develop a broad and vigorous program in Preventive Medicine and Public Health, the Department has been completely divorced from the Student Health Program and its educational and research activities merged with the program of the State Laboratory of Hygiene. However, the Laboratory of Hygiene shall continue to function as a separate unit—with Doctor Evans heading both departments.

Dr. Evans has been associated with the University of Wisconsin Medical Center since 1952. He received his M.D. degree from the University of Buffalo in 1943 and took his internship and residency training at the University of Pittsburg Medical Center and Goldwater Memorial Hospital, New York. He has held various positions on the staff of Yale University and was with the U. S. Army 1945–46 as Public Health Officer, Military Government, Okayama, Japan, and from 1950 to 1952, U. S. Army Chief, Hepatitis Center and Research Laboratory, 98th Gen. Hospital, Munich, Germany. His research activities have been in the areas of epidemiology and laten viral infections.

In 1951 Doctor Evans was certified as a diplomate of the American Board of Internal Medicine. He is a fellow of the American Public Health Association.

Doctor Evans, in the capacity of Director of the State Laboratory of Hygiene, succeeds Dr. William D. Stovall, who has been its director for 44 years. Doctor Stovall officially retired July 1, 1958, but has continued as director under a special service contract. He has also agreed to continue as acting director until September 1 to allow Doctor Evans to study epidemiology and public health at the University of Michigan School of Public Health.

National Board Examinations

National Board Examinations for senior medical students are scheduled for May 21 and 22.

Glaucoma Tonography Center at Marquette

The Glaucoma Tonography Center at the Marquette University Eye Clinic is now staffed by Miss Genevieve Guilfoile, R.N., a full-time technician who has been trained to perform this specific procedure. Tests will now be done every day from Monday to Friday.

All referred patients will be interviewed by Miss Guilfoile and tested by her. Her recordings will be examined and read by Dr. Lawrence L. Garner or Dr. Richard G. Keskey and reported to the referring physician. No private patient will be interviewed or examined by any physician at the center unless he is specifically asked to do so by the referring physician.

The best results in therapy for glaucoma depend upon early recognition of the disease and tonography offers an excellent method for early diagnosis because impaired outflow of aqueous is one of the earliest findings which may be noted when the tonometric readings are normal or near normal. When a water provocative test and tonography are included, the diagnostic accuracy has been reported to be 90 per cent. Tonography can also be used to evaluate the efficacy of filtering operations and to detect the early signs of surgical failure.

The test is not to be regarded as a substitute for painstaking clinical judgment, but it does have undoubted value as one of the studies for the earlier diagnosis of glaucoma.

The Glaucoma Tonography Center is now making appointments for this service to physicians and their patients. The charge is $10.00 and repeat tests are included since no isolated test can be considered conclusive. No charge will be made to indigent patients. Please call the Eye Clinic of Marquette University, DI 4–1000, for appointments or additional information.—Lawrence L. Garner, M.D., and Richard G. Keskey, M.D., Glaucoma Tonography Center, Marquette University Eye Clinic.

To Study Needs of UW Medical School

A Committee on Long Range Planning has been appointed at the UW Medical Center to set forth a program for the next five years. The committee will consider such problems as: the adequacy of the existing research program and new research programs which should be initiated; the adequacy of the current educational program and new areas in medical education that should be developed; the desirable organization and size of the faculty; the relationship of the medical school with the graduate school and other programs across the University. In addition the relationship with the physicians of the state and other health programs and the integration of Madison hospitals into the educational programs must be considered. The committee will submit a report of its recommendations within six months.

(continued)

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$5,000 Grant to UW for Research

A grant of $5,000 has been awarded to the University of Wisconsin Medical School by the Wisconsin Chapter of the Arthritis and Rheumatism Foundation, Robert H. Rolfs, Chapter president and head of Amity Leather Products Co., West Bend, Wisconsin, announced recently.

The grant to the University's medical school will cover a year's research study into the effects of tryptophan, an essential amino acid widely distributed in animal and some plant proteins, on cases of active rheumatoid arthritis.

Dr. John Z. Bowers, Dean of the University of Wisconsin Medical School and also a board member of the Wisconsin Arthritis and Rheumatism Chapter, indicated that the new research study came about as a result of related studies. "It was found that diseases resembling rheumatoid arthritis showed changes in the metabolism of tryptophan," he explained. "Accordingly, we ran a few pilot studies on arthritics and found some interesting changes when the disease was active and advanced. The grant from the Wisconsin Chapter of the Arthritis and Rheumatism Foundation will permit a more detailed investigation of the problem in the Arthritis Clinic and the Tumor Clinic of the University Hospitals at Madison."

The Wisconsin Arthritis and Rheumatism Chapter's board of directors also authorized continuing negotiations with the Marquette University School of Medicine on a proposed clinical study of the effects of "new applications of old drugs" on arthritis. Dr. John S. Hirschboeck, Dean of the Marquette University School of Medicine and also a board member of the Wisconsin Chapter, said that he hoped the study program would be ready by June or July of this year.

In addition to supporting research studies, the Wisconsin Arthritis and Rheumatism Chapter's program includes public education through forums and through the distribution of medically approved information, including a bi-monthly newsletter, on a statewide basis. Funds for the Wisconsin Arthritis and Rheumatism Chapter's program come from public contributions during the Chapter's annual fund drive in May, and from bequests.

Anyone may receive information about arthritis and rheumatism or about the Wisconsin Chapter's activities by writing the Chapter's executive offices at 756 N. Milwaukee St., Milwaukee, Wis.

1959 Annual Alumni Day

The Loraine Hotel in Madison has been selected for the site of the UW Medical School's 1959 Annual Alumni Day meeting on May 15. To be honored at this year's festivities will be the reunion classes of '29, '39 and '49. These classes have been requested to choose their class representatives and speakers.

(continued)

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Thiamine Mononitrate.....1 mg.
Riboflavin.....1 mg.
Pyridoxine Hydrochloride.0.25 mg.
Calcium Pantothenate....0.25 mg.
Nicotinamide.....3.3 mg.
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Sterazolidin®: Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

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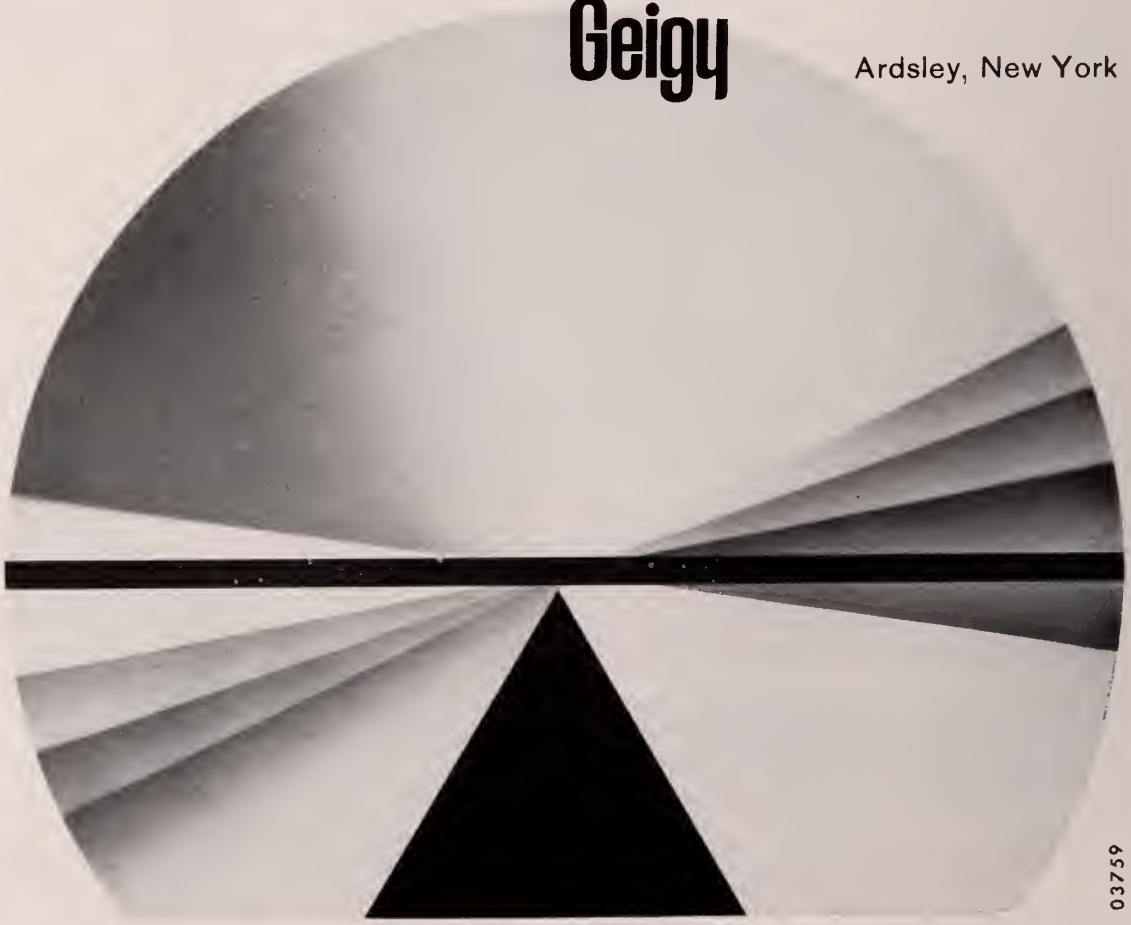

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Expanded Student Health Program

A program to offer comprehensive medical care for the spouse and dependents of undergraduate students at a reasonable cost and without the traditional referral procedures was instituted February 1 at the University Medical Center in Madison. Medical care for adults will be offered through the Student Health Department, under the supervision of Associate Professor John H. Flinn. Full obstetrical care will be available, as well as pediatric care, including well-child conferences.

This program was developed through discussions with the State Medical Society, including the Dane County Medical Society. The objective is to make available a greater diversity and volume of teaching material.

New Faculty Member at UW

Leigh M. Roberts, M.D., is an Assistant Professor in the Department of Psychiatry of the University of Wisconsin Medical School. Doctor Roberts, who assumed his new position January 1, is a former resident who received all his training at the University of Wisconsin Medical School. From 1956 until his new appointment, Doctor Roberts was a clinical instructor in psychiatry. In addition to his clinical duties, he served as staff psychiatrist at Mendota State Hospitals in Madison, as psychiatric consultant at the Wisconsin Child Center in Sparta and has been in private practice in Madison.

Doctor Roberts' primary teaching role will be in relation to third year medical clerks and first year psychiatric residents on in-patient service. He will also be administratively responsible for in-patient service for half of each year—the remaining half-year being spent in research—his particular field of interest being the effects of tranquilizing drugs on psychopathology.

Research Grants Available

Research grants—not to exceed $500—are available from the Committee on Research of the Council on Drugs of the AMA. These grants are intended to supplement grants from other sources for clinical and basic medical research. No more than two grants may be awarded to any institution and the funds are to be used only for supplies and equipment.

The deadline for filing applications is April 1. Applications may be secured from the Secretary, Committee on Research, AMA, 535 N. Dearborn Street, Chicago 10, Ill.

(continued)

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE FRANK, M. D.
WILLIAM C. JANSSEN, M. D.
LOREN J. DRISCOLL, M. D.

JOSEF A. KINDWALL, M. D.
Consultant

LEROY A. WAUCK, Ph. D.
Clinical Psychologist

The Hospital is situated on the Nashotah Lakes, 30 miles west of Milwaukee, providing the ideal, restful country environment and the facilities for the modern methods of therapy of the psychoneuroses, psychosomatic disorders, alcoholism, and the other neurologic and psychiatric problems. Occupational therapy and recreational activities directed by trained personnel.

Fellowship to Doctor Schilling

Dr. Robert Schilling, associate professor of medicine at the UW Medical School, is the recipient of a Commonwealth Fund Fellowship which enables him to spend six months abroad doing research in the field in which he has won world-wide recognition. He left March 1 for England where he is studying developments in the immunological field. Travel expenses will be paid by a grant from the University Research Committee.

Doctor Schilling is the discoverer of the Schilling Test. Doctor Schilling worked at Harvard with Dr. Wm. B. Castle, who discovered the intrinsic factor missing from the stomach of patients suffering from pernicious anemia. He returned to Wisconsin, a number of years ago, to do research into blood diseases and then developed the Schilling Test, which is known and used throughout the world for the diagnosis of pernicious anemia. At the present time he is engaged in important work in the study of leukemia and the investigation of the metabolism of Vitamin B_{12}.

Wisconsin Medical Alumni Association

The Wisconsin Medical Alumni Association recently held a meeting at the University Club in Milwaukee. Dr. Francis M. Forster, Chairman of the Dept. of Neurology of the University of Wisconsin Medical School, presented an informal talk on "Medicine in Russia." He had just returned from a 30-day tour of Russian nerve research centers sponsored by the National Institute of Neurological Diseases and Blindness. The informal lecture was illustrated with colored slides which had been taken of Russian buildings, industries and living conditions.

Dr. Mischa Lustok, currently heading the Wm. S. Middleton Library Fund drive undertaken by the Wisconsin Medical Alumni Association to establish a new medical library, reported that $190,000 has been collected from the alumni toward the goal of $850,000.

Postgraduate Course at UW

A postgraduate course on "Recent Advances in Therapeutics" was held February 19 at the Wisconsin Center Building, Madison, by the University of Wisconsin Medical School.

Guest faculty were Rachmiel Levine, M.D., Chairman, Department of Medicine and Director, Medical Education, Michael Reese Hospital, Chicago, Ill.; and David H. P. Streeten, M.D., Assistant Professor of Internal Medicine, University of Michigan School of Medicine, Ann Arbor, Michigan.

Wisconsin faculty were Frederick E. Shideman, M.D., Ph.D., Professor and Chairman, Department of Pharmacology and Toxicology; Edgar S. Gordon, M.D., Professor of Medicine; Robert E. Parks, Jr., M.D., Ph.D., Associate Professor of Pharmacology and Toxicology; J. LeRoy Sims, M.D., Associate Professor of Medicine; and Donald W. Smith, Ph.D., Associate Professor of Medical Microbiology.

Subjects covered included: "Oral Hypoglycemics," "Treatment of Resistant Infections," "Adrenal Cortical Steroids and Related Substances," and "Newer Hypnotic and Sedative Agents."

VISITING NURSE SERVICE

Rheumatic Fever Clinic at St. Mary's Hospital
Madison, Wisconsin

The Rheumatic Fever Clinic at St. Mary's Hospital, Madison, is held every Thursday morning for medical consultation. Appointments are made by the referring physician through the Visiting Nurse Service, Miss Anne Thiessen, R.N., Telephone: Alpine 5–9471. Dr. Richard H. Wasserberger has replaced the late Dr. John A. Beyer as the cardiologist.

This Clinic is supported by Kiddie Camp, Inc., the Visiting Nurse Service, the Bureau for Handicapped Children and St. Mary's Hospital.

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Medical Meetings - Postgraduate Courses

Wisconsin Association of Blood Banks

The 1959 annual meeting of the Wisconsin Association of Blood Banks will be held in Madison on Saturday, April 11. Headquarters will be at the Ivy Inn, 2355 University Avenue. The meeting is open to the public as well as members of the Association. A $2.00 registration fee is required for nonmembers.

The morning session will be held at the Veterans Administration Hospital. Dr. William Young and his staff from the University Hospitals will present a program on open heart surgery, with a demonstration of the pump-oxygenator.

After a buffet lunch at the Ivy Inn, several papers relating to blood banking will be presented. The annual dinner will be held at the Cuba Club in the evening.

Advance reservations are requested for those persons wishing to attend the luncheon and dinner. Luncheon tickets are $1.50, dinner tickets, $3.50. Reservations are to be sent to the office of the Secretary, and additional information may be obtained from this office: Mr. J. N. Fosshage, Secretary, Wisconsin Association of Blood Banks. P. O. Box 603, Madison 1, Wisconsin.

TENTATIVE PROGRAM

VETERANS ADMINISTRATION HOSPITAL—2500 Overlook Terrace, Madison

A.M.

9:00 Registration
Coffee—courtesy of the Veterans Administration Hospital

9:45 Opening Remarks
Morris Thomas, M.D.—Manager, VA Hospital
E. S. Olson, M.D.—President, WABB

10:00 Open Heart Surgery—William Young, M.D. University Hospitals

11:30 Tour of the Hospital

IVY INN—2355 University Avenue, Madison, Wisconsin

P.M.

12:30 Buffet Lunch and Business Meeting

2:30 Insurance Coverage of Blood Banks—Raymond F. Ambelang, Milwaukee Blood Center

2:50 Problems in Blood Distribution—Robert A. Freeman, American National Red Cross

3:10 Treatment of Sickling Disease by Transfusion—Robert Hines, M.D., VA. Hospital

3:30 Coffee Break

3:45 Significance of Leuko-agglutinins in Transfusion Practice—T. G. Greenwalt, M.D., Milwaukee Blood Center

4:05 Current Status of the Michigan Blood Derivatives Program—H. D. Anderson, Ph.D. Division of Laboratories, Michigan Department of Health

4:35 Closing Remarks

CUBA CLUB—3416 University Avenue, Madison, Wisconsin

5:30 Social Hour

6:30 Dinner and Entertainment

UW Postgraduate Course

A postgraduate course, "Pathology and Radiology of the Skeletal System," will be held May 21, 22, 23, at the Wisconsin Center Building, by the University of Wisconsin Medical School. The program will be of special interest to radiologists, pathologists, orthopedic surgeons, pediatricians and others.

The program will consist of formal talks by guest speakers, open discussion and panels for the discussion of cases of unusual interest.

Guest speakers include: Dr. Louis Lichtenstein, chief pathologist, Veterans Administration Center, Los Angeles, Calif.; Dr. E. B. C. Neuhauser, radiologist in chief, Children's Medical Center, Boston, Mass.; Dr. David G. Pugh, Department of Roentgenology, Mayo Clinic, Rochester, Minn.; and Dr. H. J. Spjut, associate professor of surgical pathology, Washington University, St. Louis, Mo.

Members of the UW faculty include: Drs. E. C. Albright, D. M. Angevine, J. R. Cameron, E. S. Gordon, W. H. Jaeschke, J. H. Juhl, J. J. Lalich, C. C. Lobeck, L. W. Paul, and H. W. Wirka.

For further information contact: Dr. Robert C. Parkin, Coordinator of Graduate Medical Education, 418 N. Randall Ave., Madison, 6, Wisconsin.

Wisconsin Trudeau Society

Members of the staff of the Madison VA Hospital and faculty of the University of Wisconsin Medical School will present the program at the annual spring meeting of the Wisconsin Trudeau Society on Saturday, April 25, at the Madison VA Hospital.

Headlining the agenda are reports on, "Four Year Follow-up of 350 Pulmonary Resections for Tuberculosis," by Dr. John T. Mendenhall, chief of thoracic surgery, VA Hospital; and, "Experiences with the Use of Amphotericin B in the Treatment of Pulmonary and Systemic Mycoses," by Dr. Helen A. Dickie, professor of medicine and chief of section of chest diseases, UW Medical School.

The society president, Dr. Einar R. Daniels, Milwaukee, will deliver a dinner address on, "What

(continued)

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Can the Trudeau Society Do to Serve the Physicians and Health Services of the State?" Saturday evening.

The program will open at 9:45 a.m. with a welcome by Doctor Daniels and will continue until 4:00 p.m., with a social hour and dinner to follow.

Papers will be presented on: Traumatic rupture of the bronchus with surgical reconstruction; Pulmonary function in immediate post-thoracotomy period; A method for determining arterial CO_2 tension; Use of pulmonary function tests in diagnosis of some congenital heart diseases; Unusual cases of nontuberculous pulmonary disease and the role of surgery in diagnosis; Alveolar proteinosis; Anonymous (atypical) acid-fast bacilli; Viral pneumonitis; Q–fever in Wisconsin; Hyperventilation syndrome; Electrocardiographic features of advanced pulmonary emphysema; and Cyanosis in the newborn.

International Academy of Proctology

The Eleventh Annual Convention of the International Academy of Proctology will be held at The Plaza, New York City, April 5 through 9. The international, national, and local program committees are planning an unusual seminar on practical technics for office and hospital. There will be special emphasis on anal and rectal panel presentations, and on newer treatment methods.

For further information: Alfred J. Cantor, M.D., Executive Secretary, International Academy of Proctology, 147–41 Sanford Avenue, Flushing 55, L.I., New York.

Gill Memorial Eye, Ear and Throat Congress

The Gill Memorial Eye, Ear and Throat Hospital and The Elbyrne G. Gill Eye and Ear Foundation will present the thirty-second annual spring Congress in ophthalmology, otology, rhinology, laryngoscopy, maxillofacial surgery, bronchoscopy and esophagoscopy on April 6 through 11 at Roanoke, Virginia.

(continued)

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LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

Youth Conference on the Atom

The first national Youth Conference on the Atom will take place in Atlantic City, N. J., on April 30 and May 1. The purpose of the conference is to present to the nation's most able high school science students and teachers an authoritative picture of the peaceful atom in all its various applications, and probably more important, to help advance interest in the study of science among the nation's youth.

Some 500 students and teachers from high schools all over the country will participate in the conference, and they will represent winners of local science fairs, special written examinations, and in other ways, the top science students in the country.

The program will bring together, too, the most distinguished leaders in the field of atomic energy. These include: John A. McCone, chairman of the Atomic Energy Commission; Dr. John Laughlin, chief of the division of physics at Sloan-Kettering Institute for Cancer Research, who will speak on the role of the atom in medicine.

The program for the Youth Conference is being arranged by the Electric Companies Public Information Program.

Phi Lambda Kappa Fraternity

The Seventh Annual Interim Scientific Meeting of Phi Lambda Kappa, national medical fraternity, will be held at the Deauville Hotel, Miami Beach, Florida, April 5 to 12.

The five-day program, starting Monday, April 6, will be for the benefit of the general practitioner and will feature papers and symposiums by specialists in their fields. All members of the medical and dental professions are welcome.

For registration and information, write Dr. Samuel L. Lemel, 1621 Euclid Ave., Cleveland 14, Ohio.

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Summer School of Alcohol Studies

The Summer School of Alcohol Studies of the Laboratory of Applied Biodynamics, Yale University, will hold its seventeenth annual session in 1959 during the 4-week period June 28–July 23 inclusive.

The course consists of a series of lectures and 22 seminar hours. The lecture program is organized to present a systematic background of understanding necessary before evaluation of more specialized problems can be undertaken in the seminars. Lecturers are drawn from the Yale University faculty and from other institutions. Specialists in various fields—medicine, religion, education, public health—will also address the student body.

Seminars are organized to meet the particular interests of educators, clergy, physicians, social workers, nurses, psychologists, and enforcement and correctional officers. Special problems in rehabilitation of homeless alcoholics will also be explored.

During 1959 emphasis will be placed on the public health aspects of alcoholism in a Public Health Seminar. Particular attention will be given to alcoholism as an adult health problem, alcoholism and tuberculosis, the epidemiology of alcoholism, community mental health as a factor in prevention, and administrative responsibilities of state and local health departments in relation to alcoholism treatment services.

The fee of $275 covers University registration, tuition, room and board (excepting meals on Sunday). Information concerning academic credit and application forms may be secured from the Registrar, Summer School of Alcohol Studies, Yale University, 52 Hillhouse Avenue, Yale Station, New Haven, Connecticut.

American Academy of General Practice

What does the "space age" mean to medicine? How do doctors treat bad burns? What's new in the realms of heart surgery, foot fractures, hypertension and diabetes? These and countless other questions will be answered at the American Academy of General Practice eleventh Annual Scientific Assembly, April 6–9, in San Francisco's Civic Auditorium.

The scientific program will feature 28 prominent physician-authorities. More than 100 scientific and 300 technical exhibits will be prepared for the 7,000 physicians and guests expected to attend. The Academy is the nation's second largest medical association and the only American medical group organized strictly for "family doctors."

Mac F. Cahal, executive director of the 25,000-member organization, says the 1959 scientific program offers an exciting and valuable postgraduate education opportunity for physicians. Of the more than 100 national medical associations, the Academy is the only one that requires its members to do continuing postgraduate study. Each member must complete 150 hours of accredited postgraduate study every three years. Only in this way, the Academy believes, can physicians learn about medicine's newest discoveries and techniques. For this reason, the Assembly plays a vital role in the Academy's study program. This year, subjects range from surgery and public health to animal diseases and immunization.

A Wisconsin physician, Dr. Walter Blount, will be a guest lecturer during the Wednesday afternoon, April 8, session. Doctor Blount, of Marquette University School of Medicine, Milwaukee, will lecture on orthopedics. He says that fractures in children are different, and points out that elbow fractures can be the most troublesome in young patients.

Additional highlights of the Assembly include the presentation of ten $1,000 general practice residency training awards. The two Academy members who have contributed the most significant scientific articles published in *GP*, the Academy's monthly magazine, during 1958 will each receive an award of $1,000.

Bahamas Conferences

Bahamas Conferences to be held at the British Colonial Hotel, Nassau, Bahamas, are as follows:

- March 30–April 11, 1959: Seventh Bahamas Medical Conference.
- November 27–December 17, 1959: Eighth Bahamas Medical Conference.
- December 28, 1959–January 16, 1960: Second Bahamas Surgical Conference.
- January 17–Jan. 30, 1960: Second Bahamas Serendipity Conference.
- Apr. 1– Apr. 14, 1960: Ninth Bahamas Medical Conference.
- Nov. 25–Dec. 16, 1960: Tenth Bahamas Medical Conference.
- Dec. 27, 1960–Jan. 14, 1961: Third Bahamas Surgical Conference.
- Jan. 15–Jan. 28, 1961: Third Bahamas Serendipity Conference.
- Apr. 3–Apr. 15, 1961: Eleventh Bahamas Medical Conference.

Special hotel rates have been arranged for participants in the Conferences and their families. An official certificate of attendance will be issued to those taking part in the Conferences.

There are no tropical illnesses in Nassau. The average temperature during the winter months is around 70 degrees. American and Canadian citizens do not require passports. Vaccination certificates are not now required.

There are direct flights to Nassau from Miami, Fort Lauderdale, New York, and Toronto, and boats from New York and Miami.

For further information, contact: Dr. B. L. Frank, Organizing Physician, Bahamas Conferences, P. O. Box 4037, Fort Lauderdale, Fla.

(continued)

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University of Wisconsin Medical School

Postgraduate Course

Problems of the Newborn Period

April 2–4, 1959

Wisconsin Center Building, Madison

This two and one-half day course is being presented for pediatricians. The scope of the course will be limited to problems of the newborn period and will feature five distinguished guest faculty. Significant current research and practical advances in newborn care will be stressed. In addition to the lectures there will be pertinent case presentations and small seminar type group discussions. At the end of each afternoon the group will be divided into five sections, each of which will hold an informal seminar with one of the guest faculty.

PROGRAM

Thursday, April 2

A.M. NUTRITION AND METABOLIC PROBLEMS
Dr. David W. Smith, Chairman

9:00 Lecture
Dr. Edward L. Pratt (Texas)

10:30 Case presentations with panel discussions
Drs. Edward L. Pratt, Julius B. Richmond (New York), Heinz F. Eichenwald (New York), Charles Lobeck (UW), and David W. Smith (UW)

P.M. EMOTIONAL PROBLEMS
Dr. H. Kent Tenney, Jr., Chairman

1:00 Lecture
Dr. Julius Richmond

2:30 Case presentations with panel discussion
Drs. Julius B. Richmond, Clement A. Smith (Massachusetts), Richard Day (New York), H. Kent Tenney, Jr. (UW), Harold Borenz (UW)

3:30 Break into groups

3:45 Seminar discussion groups

5:00 End of seminar

Friday, April 3

A.M. INFECTIOUS DISEASE IN THE NEWBORN PERIOD
Dr. Nathan J. Smith, Chairman

9:00 Lecture
Dr. Heinz F. Eichenwald

10:30 Case presentations with panel discussion
Drs. Heinz, F. Eichenwald, Edward L. Pratt, Julius B. Richmond, Nathan Smith (UW), Kenneth B. McDonough (UW)

P.M. RESPIRATORY PROBLEMS
Dr. W. Theodore Bruns, Chairman

1:00 Lecture
Dr. Clement A. Smith

2:30 Case presentations with panel discussion
Drs. Clement A. Smith, Edward L. Pratt, Richard Day, Arthur A. Siebens (UW), George Maxwell (UW), W. Theodore Bruns

3:30 Break into groups

3:45 Seminar discussion groups

5:00 End of Seminar

6:00 Social Hour

7:30 Dinner with entertainment

Saturday, April 4

A.M. PROBLEM OF ICTERUS
Dr. C. William Reiquam, Chairman

9:00 Lecture
Dr. Richard Day

10:30 Case presentations with panel discussion
Drs. Richard Day, Clement A. Smith, Heinz F. Eichenwald, C. William Reiquam, Nathan Smith, Harry Waisman

11:30 Summary review

12:00 End of course

GUEST FACULTY

Richard Day, M.D., Professor of Pediatrics, State University of New York, Downstate Medical Center, Brooklyn, New York

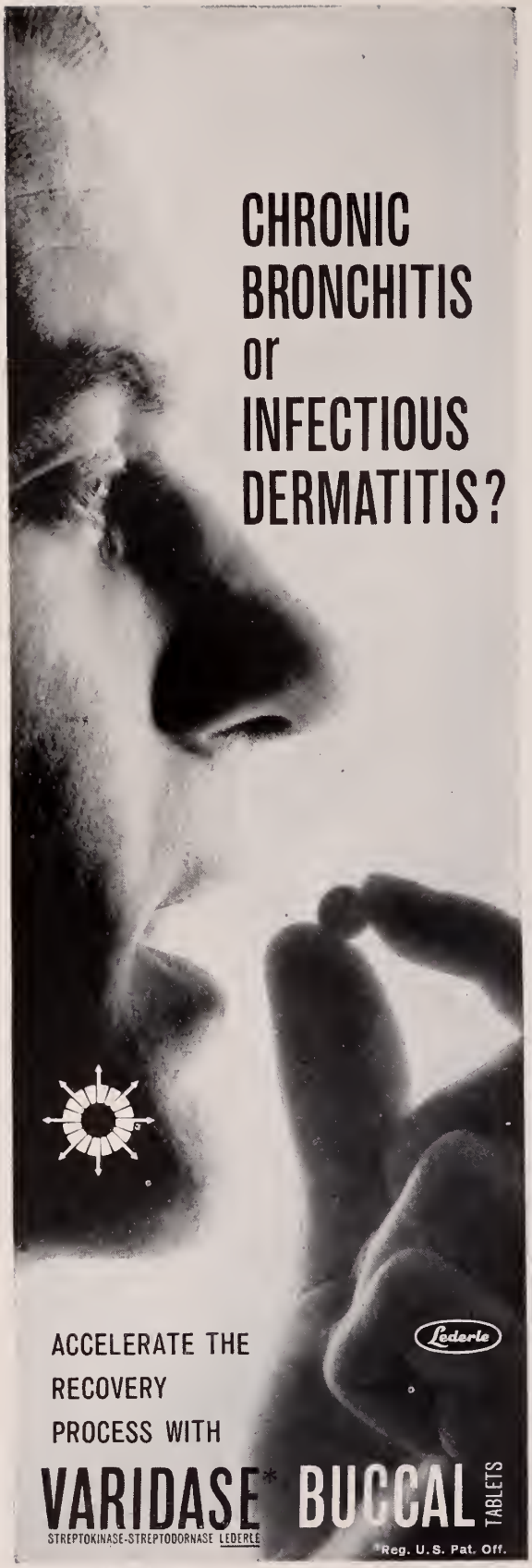
Heinz F. Eichenwald, M.D., Associate Professor of Pediatrics, Cornell University Medical College, New York, New York

Edward L. Pratt, M.D., Professor and Chairman, Department of Pediatrics, Southwestern Medical School, Dallas, Texas

Julius B. Richmond, M.D., Professor and Chairman, Department of Pediatrics, State University of New York, Upstate Medical Center, Syracuse, New York

Clement A. Smith, M.D., Professor of Pediatrics, Harvard Medical School, Boston, Massachusetts.

For further information contact: Dr. Robert C. Parkin, 418 N. Randall Ave., Madison 6, Wisconsin.



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Biological Photographic Association

The first Midwestern Sectional Meeting of the Biological Photographic Association will take place in Iowa City, Iowa, April 24–26 at the University of Iowa. Distinguished photographic specialists in medicine, dentistry, biology, and other sciences will attend, representing major medical and dental schools, hospitals, research institutions and science centers from Canada and nine midwestern states—Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North and South Dakota, and Wisconsin.

A fascinating salon of color and black-and-white photographs will feature striking displays of clinical and specimen photography, photomicrography (photographs through a microscope) and natural science. A motion picture program is scheduled for Friday evening, April 24, reviewing new medical and scientific films.

The Biological Photographic Association is the only professional society in the United States dedicated to the skills of medical and scientific photography. Founded at Yale University in 1931, the world-wide membership includes physicians, medical editors, educators in the fields of medicine and science, and staff photographers of medical and scientific institutions. The Association issues the authoritative *Journal of the Biological Photographic Association*, a quarterly publication of illustrated articles on scientific photography, motion pictures and photomicrography in color and monochrome.

For further information: Mr. Carroll H. Weiss, Director of Professional and Press Publicity, 160 Riverside Drive, New York 24, N.Y.

Association of American Physicians and Surgeons

The Association of American Physicians and Surgeons, a national organization representing the nation's physicians in medical economics, public relations, legislation and freedom, will hold its Sixteenth Annual Meeting of the Assembly and Delegates at Fort Worth, Texas, on April 2, 3 and 4. All physicians who are members of their county medical societies are eligible to attend the sessions, whether or not they are members of AAPS.

For further information, contact: William L. Baughn, M.D., Secretary, Anderson, Ind.

The Society of Nuclear Medicine

The sixth annual meeting of The Society of Nuclear Medicine will be held at the Palmer House, Chicago, Illinois, Thursday, Friday, and Saturday—June 18–20. Reservation forms for the Palmer House and a list of hotels and motels in the immediate vicinity will be mailed to the membership in approximately one month.

Additional information may be obtained by writing to Samuel N. Turiel, Administrator, The Society of Nuclear Medicine, 750 North Michigan Avenue, Chicago 11, Illinois.

(continued)

University of Minnesota Courses

Medical continuation courses to be presented at the Center for Continuation Study, University of Minnesota, are:

March 30–April 3: Basic Concepts of Water and Electrolyte Balance for General Physicians.

April 2–4: Emergency Surgery for General Physicians.

April 6–8: Radiology for General Physicians.

April 16–18: Allergy for General Physicians and Specialists.

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minn.

Chicago Committee on Trauma

The Third Annual Post-Graduate Course in Fractures and Other Trauma will be presented by the Chicago Committee on Trauma of the American College of Surgeons from Wednesday, April 15, through Saturday noon, April 18, at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago 11, Illinois.

Among the guest speakers will be Dr. Walter P. Blount, Milwaukee.

Registration fee for the Course is $75. Residents, interns and students will be admitted free, if a note of identification from chief of service or dean is presented.

American College of Chest Physicians

The American College of Chest Physicians will hold its Silver Anniversary meeting at the Ambassador Hotel, Atlantic City, June 3–7, 1959. The scientific program will include prominent speakers on all aspects of heart and lung diseases. In addition to formal presentations, there will be a number of symposia, round table luncheon discussions, postgraduate seminars, and motion pictures.

Fireside Conferences, inaugurated in 1955, will feature more than 60 experts in chest disease leading discussions on topics of current interest.

Examinations for Fellowship in the College will be held on Thursday, June 4, and on Thursday evening, more than 200 new Fellows will receive their certificates of Fellowship at the Convocation. The Presidents' Banquet and annual dance will take place on Saturday, June 6.

It is expected that a number of physicians from other countries will attend the 25th Annual Meeting.

Dr. Donald R. McKay, Buffalo, New York, President of the College, has announced that to commemorate the Silver Anniversary, the College is publishing a history of the growth of the organization since its first meeting in 1935.

Aero Medical Association

Retirement point credits may be earned by reserve Medical Corps officers who attend the scientific sessions of the thirtieth annual meeting of the Aero Medical Association in Los Angeles, California, April 27–29, the Department of Defense announced recently. This authorization covers eligible physicians who are Medical Corps officers of the reserve components of the U. S. Army, Navy and Air Force on inactive status.

The wide interest in man's impending venture into space is expected to bring more than 1,500 members of the Association and their guests to Los Angeles, according to Brigadier General M. S. White, USAF (MC), Washington, D. C., president of the Association. Latest advances and developments in aerospace medicine of nearly 200 scientists from the United States and several foreign countries will be presented.

International Symposium on Myasthenia Gravis

The Myasthenia Gravis Foundation, Inc., and The National Institute of Neurological Diseases and Blindness will jointly sponsor the second international symposium on myasthenia gravis on April 18 and 19 at the Statler–Milton Hotel, Los Angeles, Calif. Physicians and students are welcome. There will be no registration fee. For further information contact: Kermit E. Osserman, M.D., F.A.C.P., 4 East 89th Street, New York 28, N. Y.

North Shore Hospital Lecture

The seventh lecture in the Ninth Annual North Shore Hospital Lecture Series on "Emotional Forces in the Family" will be held at the hospital, 225 Sheridan Road, in Winnetka, Illinois, on Wednesday, April 1, at 8:00 p.m.

"The Individual, the Family, and the Community" will be discussed by Judd Marmor, M.D., Clinical Professor of Psychiatry, School of Medicine and Visiting Professor of Social Welfare, University of California at Los Angeles; Training Analyst and Past President, Institute for Psychoanalytic Medicine of Southern California.

The Commission on Education of the American Academy of General Practice has approved these lectures for Category II credit. Doctor Marmor has agreed to answer questions after his presentation. All physicians and allied professional personnel welcome to attend.

American Goiter Association

The 1959 meeting of the American Goiter Association will be held in the Drake Hotel, Chicago, Ill., April 30, May 1 and 2. The program for the three-day meeting will consist of papers and discussion dealing with the thyroid gland, its physiology, pharmacology, pathology, and therapy.

For further information: John C. McClintock, M.D., Secretary, 149½ Washington Avenue, Albany 10, N.Y.

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Obituaries

Dr. R. F. Braun, a retired physician, died October 13, 1958, after a lingering illness. He was 74 years of age.

Doctor Braun was born in Wausau in 1884 and graduated from Marquette University School of Medicine in 1915. He was a veteran of both World Wars, practiced in Milwaukee and Wausau, and in 1946 became a member of the staff at the Winnebago Institute. He remained there until retirement about four years ago. Because of ill health Doctor Braun returned to Wausau last April to reside with a sister.

He was a former member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include a sister and two brothers.

Dr. George E. Coon, 88, died October 26, 1958. He was residing in Milton at the time of his death.

Born in 1870, Doctor Coon received his medical education at the University of Illinois, graduating from its medical school in 1898. He spent the next 40 years practicing in Rock County at Hanover, Rockdale and primarily at Milton Junction. He entered retirement in the 1930's. In recent years he had been spending his winters in Riverside, California, and the remaining time at his daughter's home in Milton.

Surviving are his daughter, Mrs. Leland Shaw, and a son, Dr. George W. Coon, Riverside, California.

Dr. A. A. Hoyer, who practiced over 50 years in Wisconsin, died November 3, 1958, in Phoenix, Arizona, where he had been spending his retirement since 1956.

Born in Platteville, 1879, Doctor Hoyer received his medical degree from the Marquette University School of Medicine in 1906. During 1906 he interned at Trinity Hospital in Milwaukee. The first 19 years of Doctor Hoyer's medical practice were spent in Randolph. He moved to Beaver Dam in 1928 where he remained until retirement. Several years ago he established the Hoyer Clinic with his son, Dr. Charles E. Hoyer.

He was a member of the Dodge County Medical Society, a life member of the State Medical Society of Wisconsin, and the American Medical Association. He was also a member of the State Society's Fifty-Year Club.

Besides his widow, three sons, Dr. Charles, Beaver Dam; William, La Crosse; and David, Phoenix, Arizona; and a daughter, Jane, Madison, survive.

Dr. A. J. Schmitt of Sheboygan died unexpectedly November 7, 1958, while attending a medical convention in Chicago. He was 54 years of age.

Doctor Schmitt was born in 1904 at Sheboygan where he virtually spent his entire life. A 1931 graduate of the University of Wisconsin Medical School, he interned and served a residency at Long Island College Hospital in New York. His Sheboygan practice began in 1934 and he specialized in urology. He was chief of urology at Sheboygan Memorial Hospital, attending urologist at St. Nicholas Hospital, and consulting urologist at Rocky Knoll Sanitarium and St. Alphonsus Hospital in Port Washington.

His society affiliations include memberships in the Sheboygan County Medical Society, of which he was past president; the State Medical Society of Wisconsin; the American Medical Association; the Wisconsin Urological Society; the North Central Branch of the American Urological Society; and the American Venereal Disease Society.

His widow together with three children survive.

Dr. E. C. Neumann of Milwaukee died November 19, 1958, at the age of 78.

Doctor Neumann was born in Freistadt in 1880. He graduated from the University of Wisconsin pharmacy school in 1901. Before attending medical school he operated a drugstore at West Bend. Following graduation from the Marquette University School of Medicine in 1914, he opened a pharmacy at Berlin, later selling that and moving to Milwaukee where he purchased another. In 1930 Doctor Neumann established an office for the practice of medicine and remained there until retirement.

Surviving are two daughters, Mrs. L. D. Graber, Oshkosh; and Sister M. Marguerite Christine B.V.M., Dubuque, Iowa; and one son, Robert, East Troy.

Dr. C. J. Smiles, an Ashland physician and surgeon, passed away November 19, 1958, at the age of 71.

A native of Pennsylvania, having been born at Pittston in 1885, he attended the University of Pennsylvania, receiving his medical degree in 1911. From 1911–12 he interned at St. Joseph's Hospital, Ashland, where he remained to begin practice. Doctor Smiles retired in 1956 but continued to head the C. J. Smiles medical group which he founded in 1932. He had served as the president of both St. Joseph's and Trinity Hospitals and was surgeon for the Chicago and Northwestern Railway and the American Railway Association for many years. Doctor Smiles was also instrumental in the establishment of the Ashland General Hospital.

He was a member of the Ashland–Bayfield–Iron County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the Radiological Association of North America. From 1940 to 1945 he was a member of the Scientific Council of the State Society.

Survivors are his widow and four children, Dr. William Smiles, a physician in Ashland; Mrs. Bernard Josephson, Ashland; Mrs. Roy K. Hanson, Racine; and Mrs. Geoffrey Watson, Eau Claire.

Dr. Ernest L. Jewell, a Loganville general practitioner for 23 years, succumbed November 22, 1958, at his home. He was 62 years of age.

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Born in Richland Center in 1896, Doctor Jewell attended the University of Wisconsin where he received his Bachelor of Science degree. He obtained his medical education at Rush Medical College, graduating in 1924, and interned at Madison General Hospital for one year. He immediately set up practice in Loganville where he remained for his entire career. He was a member of the medical staffs of the Reedsburg and Richland Hospitals.

Doctor Jewell was a member of the Sauk County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Adele, and one son, Richard, a student at Marquette University.

Dr. Clemens Messmer, a Milwaukee eye, ear, nose and throat specialist for more than 50 years, succumbed December 3, 1958, following an accident in which he was struck by an automobile. He was 77 years of age.

Doctor Messmer was born in 1881 and graduated from Milwaukee Medical College in 1903. He practiced general medicine in Pine River for two years before going to Vienna, Berlin and Breslau for specialty training. Upon his return to the United States in 1907, he studied under one of the best known eye, ear, nose and throat specialists in the nation before establishing his Milwaukee practice.

Memberships held by him were those with The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the Milwaukee Oto-Ophthalmic Society.

Two brothers, Henry and John, both of Milwaukee, survive.

Dr. H. B. Norviel, 64, died at his Phillips home December 7, 1958, following a lingering illness.

He was born at Olney, Illinois, in 1894, graduated from the University of Illinois Medical School in 1920 and served an internship at Grant Hospital, Chicago, the same year. Upon graduation he practiced in Chicago and was also on the University staff at Champaign, Illinois. In 1925 he came to Wisconsin to practice in Tigerton and after a short time relocated in Phillips.

Doctor Norviel was a member of the Price–Taylor County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Immediate survivors are his widow, his mother, and two daughters.

Dr. E. H. Brooks of Bloomington succumbed December 17, 1958, at the age of 86. He had been retired for the past six years.

A native of Bloomington, born in 1872, he graduated from Hahnemann Medical College in 1897 and served an internship and residency at the hospital there. Upon completion of his studies he practiced for one year at Bloomington. He spent the next year as assistant medical director of the Indiana Mineral Springs Sanitarium in Attica, Indiana, returning to Wisconsin at the close of 1899 to practice in Appleton. He was founder and first president of the Appleton Eye, Ear, Nose and Throat Clinic. He moved to Bloomington upon retirement.

Doctor Brooks was a member of the Outagamie County Medical Society, the State Medical Society of Wisconsin (holding the honor of life membership), the Fifty-Year Club of the State Society, the American Medical Association, the Academy of Eye, Ear, Nose and Throat, and the Central Wisconsin and Upper Michigan Eye, Ear, Nose and Throat Society.

Two daughters, Mrs. Virginia Jefferson of Milwaukee, and Mrs. James Robbins of Bedford, New York, survive.

Dr. Edwin P. Hayes, an Eau Claire obstetrician and pediatrician and a pioneer in prenatal and hospital obstetrics, died December 26, 1958, at the age of 72.

He was born in 1886 at Richfield. Doctor Hayes graduated from the Marquette University School of Medicine in 1913. After a year of internship at St. Paul Hospital, St. Paul, Minnesota, he began practicing medicine in Eau Claire. His practice was interrupted during World War I when he served in the U. S. Army medical corps, being stationed overseas for sixteen months. Upon release from military service he resumed his practice in Eau Claire and was one of the founders of the Eau Claire Clinic which was organized in 1921. From 1919 to 1924 Doctor Hayes did postgraduate work in obstetrics and pediatrics at the University of Minnesota and in hospitals in Chicago, New York, and Cleveland.

For 20 years he was a Preceptor for the University of Wisconsin medical students and for many years was an instructor for student nurses at Luther Hospital. He was a member of the Luther and Sacred Heart Hospital staffs and was a director of Associated Hospital Service, Inc. for the past 13 years.

Memberships held by him include those with the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the American College of Obstetricians and Gynecologists, and the Wisconsin Society of Obstetrics and Gynecology.

He is survived by his widow, Louise; one brother, Thomas of Richfield; one sister, Mrs. John Winter of Sheboygan Falls; and two nephews whom he reared, Chauncey C. and Kenneth F. Betz, now of Milwaukee and Sheboygan Falls, respectively.

Dr. Francis De Salvo succumbed at his Wausaukee home on January 26, 1959. He was 67 years of age.

He was born in 1891 at Chicago, Illinois. Doctor De Salvo graduated from the Chicago College of Medicine and Surgery in 1917. For the past ten years he had been in private practice at Wausaukee, having spent the previous 32 years as company physician for the Kimberly-Clark Corporation in Niagara. During the year following graduation from medical school he was located at Gay, Michigan.

Surviving are his widow, one son and a stepdaughter.

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Cancer Treatment

To Wisconsin Physicians:

The Cancer Chemotherapy National Service Center reported today that Mitomycin C, an antibiotic reported as giving promising results in cancer treatment in Japan, has frequently produced major toxic reactions but seldom objective improvement in clinical trials in the United States.

The antibiotic has been under pilot clinical evaluation in this country as an anti-tumor agent in a substantial variety of tumors. In view of the effects observed in three current studies, it has not so far replaced the standard chemotherapeutic agents in any form of cancer, the Chemotherapy Center's announcement said. Full reports on the clinical trials will appear later in the scientific literature. Meanwhile, studies of the drug are being continued.

Japanese experience in treating human cancer with Mitomycin C was reported at a Symposium on Antibiotics in Washington, D. C. October 16, 1958. A limited quantity for clinical trials in this country was produced by Bristol Laboratories for the Cancer Chemotherapy National Service Center.

U. S. Dept. of Health, Education and Welfare
Bethesda, Maryland

Research in Prevention of Blindness

To Wisconsin Physicians:

The Research Committee of the National Society for the Prevention of Blindness invites requests for research grants in 1959. Funds are available for projects that may contribute to basic understanding of eye function and pathology, or that may improve methods of diagnosis, treatment or prevention of blinding eye disease. Grants will be made this spring for requests received prior to May 1, and inquiries can be addressed to Research Committee, National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

National Society for the
Prevention of Blindness
1790 Broadway, New York 19, N. Y.

Membership Correction

To Wisconsin Physicians:

The name of Robert L. Beilman, M. D., of Madison, was inadvertently omitted from the membership roster which appeared in the January 1959 issue of *The Wisconsin Medical Journal.* We deeply regret this error. Our apologies to Doctor Beilman.

State Medical Society of Wisconsin
330 East Lakeside Street
Madison 5, Wisconsin

Please Doctor!

Each month there are a number of journals returned to the office because of a change of address which was not brought to the attention of the staff. Postage is paid for these returned journals, and additional postage paid again when sending them to the new address. It would be of much help and less expense if the Journal could be notified of these address changes at least six weeks in advance. Your cooperation will be greatly appreciated. Below is a form for your convenience.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

Clinical Obstetrics and Gynecology. Toxemias of Pregnancy, edited by Louis M. Hellman, M.D. Fibromyomas of the Uterus, edited by Robert A. Kimbrough, M.D. Volume 1, Number 2, and Volume 1, Number 3. A quarterly book series. Paul B. Hoeber, Inc., 49 East 33 St., New York 16, N. Y. 1958. Subscription price $18.00 1 year.

When this series of hard-cover periodicals was first announced about a year ago I wondered whether another addition to the obstetrical literature could possibly be justified, a literature already replete with monthly journals, a bi-monthly review, year books, and several excellent texts. I believe that the answer can now be a definite yes, that in three issues Clinical Obstetrics and Gynecology has established a distinctive niche for itself. The topics chosen (two per number) have been stimulating, often being presented from a multi-disciplinary approach, and both editors and contributors have written well, most authors being recognized authorities and investigators in their fields. There is, of course, considerable overlap in material presented, but this is hardly a defect as the approaches of the different authors vary considerably. In addition each section can thereby be read independently.

In volume 1, number 2 TOXEMIAS OF PREGNANCY (Editor Louis M. Hellman) are well reviewed. A wealth of recent research is summarized in understandable terms and its importance suggested in modern management with hypotensive agents and diuretics. (In general, research is presented almost entirely as a background for clinical application.) FIBROMYOMAS OF THE UTERUS (Editor Robert A. Kimbrough) was, in my opinion, somewhat less effectively presented. Irradiation therapy, now seldom indicated, is discussed rather fully and there is considerable emphasis on the details of surgical technique in other sections. The sections on Myomectomy and Fibroids as Causes of Infertility and Complications of Pregnancy were of considerable interest.

Volume 1, Number 3 consists of SYMPOSIUM ON SPECIAL DIAGNOSTIC AIDS (Editor C. Paul Hodgkinson) and SYMPOSIUM ON ABNORMAL UTERINE BLEEDING (Editor John I. Brewer). As is proper, both are slanted heavily toward the diagnosis of malignancy. In separate sections of the topics on special diagnostic aids, cytology is evaluated in general and as applied to peritoneal fluid and in the pregnant patient. Common techniques such as culdocentesis and hysterosalpingography are considered and newer or less commonly employed methods such as urethrocystograms and culdoscopy are presented. Theory, indications and technique are given in some detail but the clinical utility is stressed. The presentation of abnormal uterine bleeding is masterly; little more could be said. I felt that the introductory section on "Causes", itself a summary of the Northwestern University teaching as given in Brewer's textbook, was, possibly, a bit too detailed; it tended to "steal some thunder" from the following sections. The section on genital bleeding in children was particularly welcome and nicely done.

The volumes are well "gotten up" with pleasant format and good proofreading. Indexing is adequate; the bibliographies vary from comprehensive to nonexistent. In summary, the series would appear to be a must for hospital libraries; in addition many practitioners will want a file for personal reference.
—*William Kiekhofer*

* * *

New Bibliography of Aviation Medicine Published by Areo Medical Association

The Aero Medical Association, in cooperation with the Library of Congress, has published a comprehensive annotated bibliography of aviation medical literature for 1953, according to an announcement by Brigadier General M. S. White, USAF (MC), Washington, D.C., president of the society.

Entitled, *Aviation Medicine: An Annotated Bibliography, Vol. II (1953 Literature)*, the work includes 1,386 references and abstracts from nearly 200 American and foreign journals. Subsequent annual volumes will contain published reports from the literature of 1954 to the present.

Supported by the medical services of the United States Navy and Air Force, and the Royal Canadian Air Force, the Library of Congress published a compilation of 1952 aeromedical literature two years ago. It was widely received by librarians and by flight surgeons, physiologists, psychologists and human engineers working in the broad field of aviation and space medicine. The new volume includes for the first time titles from Russian literature, and attempts to cover all the relevant peripheral areas of flight medicine. It contains a cumulative author and subject index of references in both Volumes I and II. The book was compiled by a team of research scientists in the bibliography section of the Library, headed by Arnold J. Jacobius, Ph.D.

The new bibliography is available from the publication office of the Aero Medical Association, 2642 University Avenue, St. Paul 14, Minnesota. The price is $5.00, sent postpaid in the United States and Canada.

Recent Wisconsin Licentiates

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, October 17, 1958.

Name	*School of Graduation*	*Year*	*City*
Barton, Michael	University of Basel	1948	Raton, New Mexico
Bell, D. B., II	University of Rochester	1955	Madison
Bennett, W. E.	University of Oklahoma	1953	Milwaukee
Berkley, M. C.	Johns Hopkins University	1950	Janesville
Berney, J. W.	University of Iowa	1955	Madison
Case, Q. C.	St. Louis University	1956	Racine
Childers, G. A.	University of Iowa	1954	Brookfield
Christofersen, H. R.	University of Illinois	1957	Eau Claire
Clark, P. W.	Northwestern University	1951	Watertown
Crocker, L. G.	Washington University	1955	Madison
Crummy, A. B., Jr.	Boston University	1955	Madison
Dizon, V. S.	University of Louisville	1956	Fredonia
Emerson, A. H.	Rush Medical College	1925	Brooklyn, New York
Foley, W. A.	University of Minnesota	1956	Minneapolis, Minnesota
Gronvall, J. A.	University of Minnesota	1956	Minneapolis, Minnesota
Hall, F. M.	New York Medical College	1956	Milwaukee
Hart, L. E. Jr.	Northwestern University	1950	Green Bay
Howland, W. J., Jr.	Kansas University	1950	Milwaukee
Jenkinson, D. L.	Northwestern University	1927	Chicago, Illinois
Johnson, O. G.	Nebraska Medical School	1954	Bayport, Minnesota
Johnson, R. H.	University of Nebraska	1952	Bayport, Minnesota
Lobeck, C. C.	University of Rochester	1952	Madison
McNamara, P. J.	New York Medical College	1953	Milwaukee
Monroe, Albert	University of Bern, Switzerland	1939	Lidenhurst, New York
Moody, J. L.	Marquette University	1955	Milwaukee
Murphy, P. J.	University of Michigan	1941	Arcadia
Nemcek, A. A.	Marquette University	1956	Winnebago
Niknejad, Ismail	Yale University	1951	Duarte, California
Pratt, C. R.	George Washington University	1955	Milwaukee
Renquest, E. A.	Jefferson Medical College	1954	Grantsburg
Schecter, J. A.	Indiana University	1954	North Chicago, Illinois
Schildkraut, D. I.	Chicago Medical School	1956	Berwyn, Illinois
Shearer, R. J.	University of Colorado	1953	Milwaukee
Sheldon, W. C.	Northwestern University	1957	Chicago, Illinois
Southwick, H. W.	Harvard Medical College	1943	Chicago, Illinois
Steinman, A. M.	Long Island School of Medicine	1949	Wood
Sumida, Shigeo	Marquette University	1957	Milwaukee
Teeter, R. R.	University of Pennsylvania	1947	Milwaukee
Whaley, R. C.	University of Wisconsin	1955	Janesville
Wheeler, B. C., Jr.	Indiana University	1955	Madison
Wilkins, G. T., Jr.	University of Illinois	1957	Milwaukee
Ziehl, R. C.	George Washington University	1957	Wauwatosa

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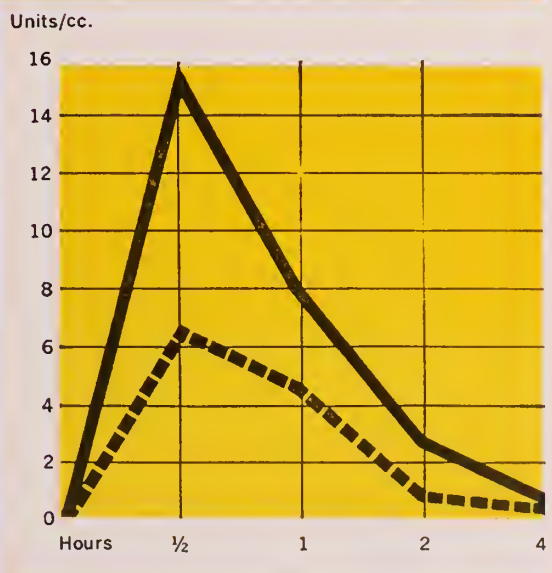

The highest levels of Filmtab Compocillin-VK.

The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

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1959 ANNUAL MEETING

TIMETABLE

MONDAY, MAY 4

a.m.—Golf tournament at North Hills Country Club
5:00 p.m.—New Delegates and Alternates meeting at Hotel Schroeder
7:30 p.m.—House of Delegates at Hotel Schroeder

TUESDAY, MAY 5

General Practice Day

8:00 a.m.—Registration at Auditorium
Exhibits open at Auditorium
9:00 a.m.—General session at Auditorium
9:00 a.m.—Reference Committees, House of Delegates, at Hotel Schroeder
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Alumni luncheons at Auditorium
2:00 p.m.—General session at Auditorium
6:00 p.m.—Buffet for Delegates and Alternates at Hotel Schroeder
7:30 p.m.—House of Delegates at Hotel Schroeder
8:00 p.m.—Fireside conferences at Hotel Schroeder

WEDNESDAY, MAY 6

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—House of Delegates at Hotel Schroeder
9:00 a.m.—General session at Auditorium
9:00 a.m.—Special program on internal medicine at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Luncheon for officers and members of SMS Charitable, Educational and Scientific Foundation at Hotel Schroeder
12:15 p.m.—Luncheon for Wisconsin Clinic Managers Association at Hotel Schroeder
2:00 p.m.—Special programs on internal medicine, obstetrics and gynecology, psychiatry, pediatrics, orthopedic and plastic surgery at auditorium
6:15 p.m.—President's reception
7:15 p.m.—Annual dinner

THURSDAY, MAY 7

8:00 a.m.—Registration at Auditorium
8:30 a.m.—Special breakfast conference and wet clinic on dermatology at Auditorium
9:00 a.m.—Exhibits open at Auditorium
11:00 a.m.--General session at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Past president's luncheon
2:00 p.m.—Special programs on anesthesia, dermatology, radiology, and surgery at Auditorium; ophthalmology and otolaryngology at Hotel Schroeder

"New Impressions in Medicine"

118th ANNUAL MEETING

State Medical Society of Wisconsin

May 5-6-7, 1959

HOTEL SCHROEDER
AND MILWAUKEE AUDITORIUM

Milwaukee, Wisconsin

SCIENTIFIC SESSIONS—SCIENTIFIC EXHIBITS—TECHNICAL EXHIBITS—SPECIAL LUNCHEONS—ROUNDTABLE LUNCHEONS—HOUSE OF DELEGATES—FIRESIDE CONFERENCES—WET CLINICS—PHOTOGRAPHIC EXHIBIT—ANNUAL DINNER—ENTERTAINMENT

ANNUAL MEETING HIGHLIGHTS

FIRESIDE CONFERENCES

Tuesday, May 5

EAST ROOM, HOTEL SCHROEDER

8:00 p.m.—FIRESIDE CONFERENCES

A series of informal "problem clinics" presented by the Wisconsin Chapter of the American College of Chest Physicians. Free beer and pretzels. "Table hop" as you wish from informal conference tables provided.

1. **DIAGNOSIS AND MANAGEMENT OF CARDIAC ARRHYTHMIAS**
   Armin R. Baier, M.D., and **Jules Chase, M.D.,** Marquette U., Milwaukee
2. **RECENT DEVELOPMENTS IN CARDIOVASCULAR SURGERY**
   Derward J. Lepley, M.D., Marquette U., Milwaukee; **James W. DuShane, M.D.,** Mayo Clinic, Rochester, Minn., and **William J. Gallen, M.D.,** Marquette U., Milwaukee
3. **PULMONARY HYPERTENSION AND COR PULMONALE**
   Irving Mack, M.D., Chicago, Ill., and **Timothy R. Murphy, M.D.,** Marquette U., Milwaukee
4. **PULMONARY FUNCTION TESTING**
   John Rankin, M.D., U. of W., Madison, and **Walter H. Thiede, M.D.,** Marquette U., Milwaukee
5. **MANAGEMENT OF PULMONARY EMPHYSEMA**
   Edwin R. Levine, M.D., Chicago, Ill., and **Albert H. Andrews, Jr., M.D.,** Chicago, Ill.
6. **PULMONARY FIBROSIS AND PNEUMOCONIOSIS**
   Helen A. Dickie, M.D., U. of W., Madison, and **Richard P. Jahn, M.D.,** Marquette U., Milwaukee
7. **MANAGEMENT OF BRONCHIAL ASTHMA AND OTHER RESPIRATORY ALLERGIES**
   Harold D. Rose, M.D., Marquette U., Milwaukee; **Clifford H. Kalb, M.D.,** Milwaukee, and **John A. Arkins, M.D.,** Marquette U., Milwaukee
8. **MANAGEMENT OF LUNG CANCER INCLUDING CHEMOTHERAPY, PALLIATIVE SURGERY, AND RADIOTHERAPY**
   Anthony R. Curreri, M.D., U. of W., Madison; **Francis B. Landis, M.D.,** Marquette U., Milwaukee, and **Maurice Greenberg, M.D.,** Marquette U., Milwaukee

WET CLINICS

Wednesday, May 6

PLANKINTON HALL, AUDITORIUM

9:00 a.m.—AMPUTATIONS AND PROSTHESIS (Wet Clinic)

Coordinator: **Walter Stenborg, M.D.,** Milwaukee County Hospital

ORTHOPEDIC INDICATIONS FOR AMPUTATION
James R. Regan, M.D., Milwaukee

VASCULAR CONSIDERATIONS IN AMPUTATIONS
Henry Twelmeyer, M.D., Milwaukee

TECHNIQUE OF AMPUTATION, STUMP CARE, AND PROSTHESIS FITTING AND TRAINING
Thomas J. Canty, M.D., Oakland, Calif.

ROLE OF THE PHYSIATRIST IN AMPUTATIONS, AND REHABILITATION FACILITIES AVAILABLE IN WISCONSIN
Edwin Welsh, M.D., Milwaukee

(Patients furnished by VA Hospital Wood and Milwaukee County Hospital)

Thursday, May 7

JUNEAU HALL, AUDITORIUM

8:30 a.m.—SPECIAL BREAKFAST CONFERENCE AND WET CLINIC ON DERMATOLOGY

(Planned in cooperation with the Wisconsin Dermatological Society)

Moderator: **Daniel E. Hackbarth, M.D.,** Milwaukee

Discussant: **Earl D. Osborne, M.D.,** Buffalo, N.Y.

Free coffee and sweet rolls! Physicians are invited to attend at 8:30 sharp so that full benefit of the teaching program can be enjoyed. Cases will be presented by Milwaukee dermatologists.

ANNUAL DINNER

EAST ROOM, HOTEL SCHROEDER

6:15 p.m.—President's Reception

BALLROOM, HOTEL SCHROEDER

7:15 p.m.—Annual Dinner

DANCING—FLOOR SHOW—SHORT SPEECHES—COCKTAILS

SPEAKER: GUNNAR GUNDERSEN, M.D.
La Crosse, President of AMA

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The possibility of gastric distress from either salicylamide or corticosteroid is minimized because of lower dosage required. This is further reduced by the buffer action of aluminum hydroxide. And the ascorbic acid helps meet the increased need for this vitamin in stress conditions. Because of the low dosage, side effects with Aristogesic have been relatively infrequent and minor in nature. However, more serious side effects have traditionally been observed on all corticosteroid therapy. Patients on long-term Aristogesic therapy should, therefore, be observed carefully.

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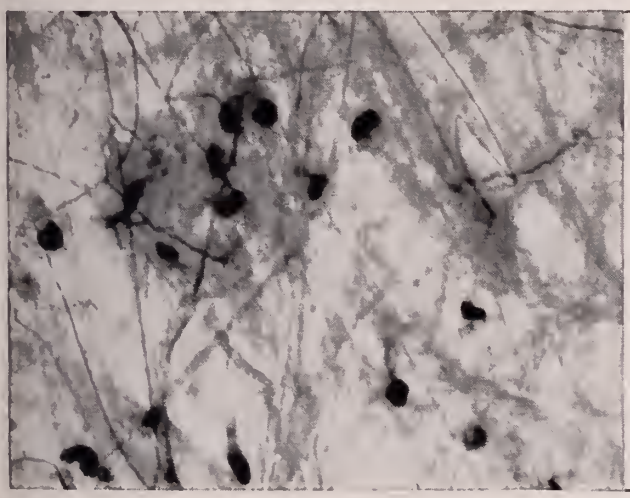

Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

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ARISTOCORT® Triamcinolone	0.5 mg.
Salicylamide	325 mg.
Aluminum Hydroxide	75 mg.
Ascorbic Acid	20 mg.

Supply: Bottles of 100.

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Roundtable Luncheons

The roundtable luncheons, which have been arranged under the direction of M. C. F. Lindert, M.D., Milwaukee, will be held at the Hotel Schroeder starting at 12:15 p.m. each day of the annual meeting. These informal gatherings are one of the highlights of the annual meeting program.

Tuesday, May 5

HOTEL SCHROEDER

1. **INDICATIONS FOR SURGERY IN GALLBLADDER DISEASE**
   E. H. Ellison, M.D., Milwaukee
2. **IDIOPATHIC ULCERATIVE COLITIS**
   C. Joseph DeLor, M.D., Columbus, Ohio
   Moderator: Joseph Shaiken, M.D., Milwaukee
3. **ETIOLOGICAL FACTORS OF CONGENITAL HEART DISEASE**
   James W. DuShane, M.D., Rochester, Minn.
   Moderator: William Gallen, M.D., Milwaukee
4. **CYSTIC FIBROSIS: A PUBLIC HEALTH CHALLENGE**
   Wynne Sharples, M.D., Boston, Mass.
   Moderator: Virginia Downes, M.D., Milwaukee
   (Following luncheon—open to all MDs—there will be a meeting of the Wisconsin Public Health Physicians)

Wednesday, May 6

HOTEL SCHROEDER

1. **DIFFERENTIAL DIAGNOSIS OF MILD, PAINLESS JAUNDICE**
   James C. Cain, M.D., Rochester, Minn.
   Moderator: J. LeRoy Sims, M.D., Madison
2. **METHODS OF CLOSURE OF ACUTE HAND INJURIES**
   John L. Bell, M.D., Chicago, Ill.
   John C. Kelleher, M.D., Toledo, Ohio
   Moderator: Wm. Frackelton, M.D., Milwaukee
3. **THE ART OF TALKING WITH PARENTS AND NOT TO THEM**
   Sherman Little, M.D., Los Angeles, Calif.
   Moderator: Ely Epstein, M.D., Milwaukee
4. **AMPUTEE REHABILITATION**
   Capt. Thomas J. Canty, MC, USN, Oakland, Calif.
   Moderator: Ray Piaskoski, M.D., Milwaukee
5. **PREINVASIVE CARCINOMA OF THE CERVIX IN PREGNANCY**
   Ronald R. Greene, M.D., Chicago, Ill.
   Moderator: Roland Cron, M.D., Milwaukee
6. **NON-MEDICINAL PRESCRIPTIONS**
   Marc Hollender, M.D., Syracuse, N.Y.
   Moderator: Bernard Kaufman, M.D., Milwaukee
7. **INFECTIONS IN THE NEWBORN**
   Heyworth N. Sanford, M.D., Chicago
   Moderator: H. Kent Tenney, M.D., Madison
8. **THE PLACE OF THE PATHOLOGIST IN A HOSPITAL ISOTOPE PROGRAM**
   Oscar B. Hunter, Jr., M.D., Washington, D.C.
   Moderator: Etheldred Schafer, M.D., Madison
   (Meeting of Wisconsin Society of Pathologists to follow luncheon)

Thursday, May 7

HOTEL SCHROEDER

1. **DIAGNOSIS OF GLAUCOMA**
   John M. McLean, M.D., New York City
   Moderator: F. Jefferson Davis, M.D., Madison
2. **CUTANEOUS MALIGNANCIES**
   Anthony C. Cipollaro, M.D., New York City
   Moderator: Joel Taxman, M.D., Milwaukee
3. **POSTOPERATIVE EXCITEMENT AND RESTLESSNESS**
   Solomon G. Hershey, M.D., New York City
   Moderator: Wilson Phillips, M.D., Milwaukee
4. **FACIAL INJURIES**
   Kenneth Devine, M.D., Rochester, Minn.
   Moderator: Lee Eby, M.D., Milwaukee
5. **NEWER DRUGS AND THEIR USES**
   Ovid O. Meyer, M.D., Madison
6. **CINERADIOGRAPHY**
   J. A. Campbell, M.D., Indianapolis, Ind.
   Moderator: Lester W. Paul, M.D., Madison
7. **DIAGNOSIS AND MANAGEMENT OF MALABSORPTION SYNDROME**
   Franz J. Ingelfinger, M.D., Boston, Mass.
   Moderator: M. C. F. Lindert, M.D, Milwaukee
8. **THE ROLE OF TRAUMA IN THE DEVELOPMENT OF PSYCHOSOMATIC DISORDERS**
   E. S. Turrell, M.D., Milwaukee

County Society Proceedings

BROWN

Forty members of the Brown County Medical Society heard *Dr. G. A. Hellmuth*, director of the cardiovascular section of Milwaukee County General Hospital, lecture on "The Treatment of Arrhythmias." Also speaking at the February 12th meeting of the society held at the Elks Club in Green Bay was *Dr. A. V. Pisciotta*, who discussed "Common Hematologic Problems in Office Practice." Doctor Pisciotta is on the staff of Marquette University School of Medicine.

During the business session the members authorized three injections and one booster of polio vaccine to be given to students in Green Bay junior high schools and high school by the Green Bay Health Department. *Dr. John Dettmann* discussed no-fee schedule insurance while *Drs. J. K. Theisen* and *Ray Waldkirch* analyzed the insurance from the doctor's viewpoint.

CHIPPEWA

On February 3 the Chippewa County Medical Society met at the Stanley Clinic in Stanley. A scientific program was presented by *Drs. J. R. Heersma*, *B. R. Lawton*, and B. S. Salibi, from the staff of the Marshfield Clinic.

Following a tour of the new Stanley Clinic, members and guests attended a dinner at the Sky Club in Thorp as guests of *Drs. A. W. Overgard* and *R. J. Mathwig*.

DANE

Members of the Dane County Medical Society met Tuesday, March 10, at the State Medical Society building in Madison. Dr. Conrad A. Elvehjem, president of the University of Wisconsin, was guest speaker. His subject was, "Some Practical Benefits from Basic Research at the University."

DOOR–KEWAUNEE

The Door-Kewaunee County Medical Society met January 27 at the Stebbins Hotel in Algoma. Speaker for the meeting was *Dr. John G. Beck*, Sturgeon Bay, who discussed, "The Management of Common Foot Ailments."

Included in the business meeting was the election of officers. Those chosen were *Drs. D. E. Dorchester*, Sturgeon Bay, president; *A. S. Lanier*, Kewaunee, vice-president; and *J. J. Brook, Jr.*, Sturgeon Bay, secretary-treasurer.

Physicians whose names are printed in italic are members of the Society.

EAU CLAIRE–DUNN–PEPIN

Dr. Charles H. Scheiffley, Rochester, Minnesota, addressed members of the Eau Claire-Dunn-Pepin County Medical Society at their February 23rd meeting at the Hotel Eau Claire on the subject of "Chest Pain and Its Meaning." Thirty-five members were in attendance.

KENOSHA

A joint meeting of the Kenosha County Medical Society and the Kenosha Manufacturers' Association was held January 15 at the Elks Club in Kenosha. Guest speaker for the occasion was Dr. Paul I. Robinson, New York City, coordinator of medical relations of the Metropolitan Life Insurance Company. He was recently elected to honorary fellowship in the American College of Hospital Administrators.

MARATHON

The Marathon County Medical Society held a dinner meeting at the Wausau Club in Wausau on February 26. During the meeting the president, *Dr. Marvin Olson*, announced the various committee appointments.

MILWAUKEE

Dr. D. F. Pierce has been appointed chairman of the Public Health Committee of The Medical Society of Milwaukee County. He succeeds *Dr. J. P. Conway*, who resigned. Doctor Conway will remain a member of the committee. *Dr. H. M. Klopf* will be vice-chairman of the committee.

Other committee appointments include *Dr. K. A. Seifert*, to the First Aid and Disaster and Medical Veterans Affairs committees and *Dr. Marvin Wagner*, to the Tissue Bank Committee.

OUTAGAMIE

On February 19 members of the Outagamie County Medical Society assembled at the Elks Club in Appleton to hear *Dr. Ralph L. Suechting*, Neenah, talk on "Acute Injuries to Central Nervous System." Also discussing the subject were *Drs. Fred Marshall* and *J. E. Gmeiner*.

In the course of the business meeting a motion was approved by vote that the society go on record opposing the corporate practice of medicine as exemplified by Bill 129-A. Action was also taken that a committee be appointed to meet with the County Board regarding the public assistance fee schedule.

(continued)

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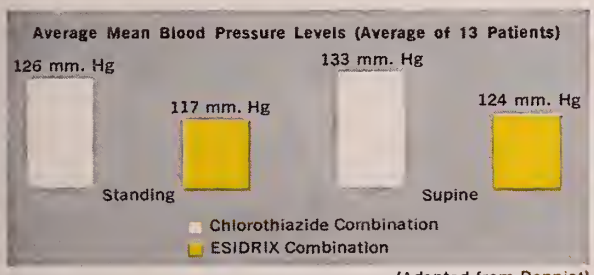
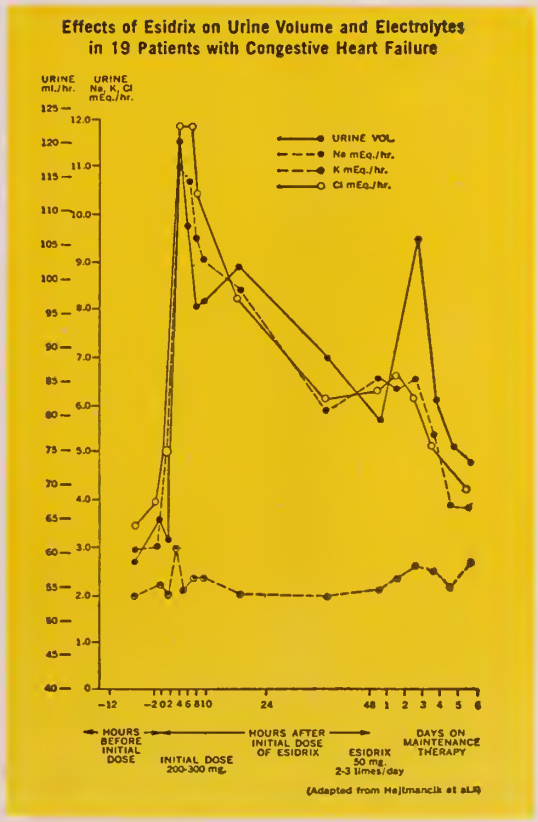


(Adapted from Dennis4)

Exceptional safety . . . reduced likelihood of electrolyte imbalance: While Esidrix markedly increases sodium and chloride excretion, it has far less effect on excretion of potassium (see chart at right) and bicarbonate. Hence, there is little likelihood of disturbing electrolyte balance when recommended procedures are followed.



DOSAGE: Esidrix is administered orally in an average dose of 75 to 100 mg. daily, with a range of 25 to 200 mg. A single dose may be given in the morning or tablets may be administered 2 or 3 times a day.

SUPPLIED: *Tablets*, 25 mg. (pink, scored); bottles of 100 and 1000. *Tablets*, 50 mg. (yellow, scored); bottles of 100 and 1000.

POLK

"The Use of Corticosteroids in General Practice" was the topic of an address given by Dr. James Melby of the University of Minnesota Department of Endocrinology at the February 19 meeting of the Polk County Medical Society held at the Dalles House in St. Croix Falls. Following the talk the new county Welfare Director, Mr. Edwin J. Hallen, was introduced.

Preschool examination forms were approved during the business meeting. Also discussed and adopted was the resolution asking for a change in the fee schedule from the County Welfare Department. The subject of Mantoux Testing in schools was referred to the Committee on Public Policy.

WALWORTH

The Walworth County Medical Society held its February 12th meeting at the F & R Steak Ranch at Elkhorn. A University Wisconsin internist, *Dr. Ovid O. Meyer*, presented a paper on "New Drugs and New Therapy."

Discussion of the hardships among physicians revealed that none were present in the county. A re-evaluation of accident coverage by physicians was undertaken, the result being that proper and effective coverage is being worked out with the sheriff's department.

WINNEBAGO

The February meeting of the Winnebago County Medical Society was held on the fifth at the Valley Inn. The meeting was held in conjunction with the Winnebago County Bar Association.

Pictured above, left to right, are: Arthur Remley, Neenah, past president of the Winnebago County Bar Association; Dr. G. O. Schwei, Neenah, president of the Winnebago County Medical Society; Dr. E. A. Strakosch, Oshkosh, county delegate to the State Medical Society House of Delegates; and L. O. Cooke, Neenah, president of the Winnebago County Bar Association. (Photo courtesy *Appleton Post–Crescent*)

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Prairie du Sac Doctors Share Office

Dr. Frank M. Roemhild has come to Prairie du Sac from Houston, Texas, to join *Dr. Milton Trautmann.* Their office will be in the Medical Arts Building of that city. Doctor Roemhild received his medical degree from the University of Illinois and practiced in Naperville, Illinois. In Houston, Doctor Roemhild was associated with the Prudential Insurance Company.

Ashland Hospital Has New Officers

St. Joseph's Hospital in Ashland has new officers following a recent meeting of the medical staff. *Dr. C. A. Grand* succeeds *Dr. H. H. Larson* as president; *Dr. George Harrison* was named vice-president; and Dr. R. A. Stanley was chosen secretary.

New Doctor in Superior

Dr. Elizabeth M. Oliveira recently became associated with *Drs. J. G. Heisel, J. P. McGinnis,* and *L.R. Rosin* of Superior. Doctor Oliveira came to Superior following graduation from Tulane University, interning in Charity Hospital, New Orleans, Louisiana, and two years as public health doctor in the Gulfport, Mississippi, area.

Doctor Grinney Attends Health Course

Dr. Leo R. Grinney, Racine, recently attended a week-long postgraduate course in pediatrics, obstetrics and gynecology at the University of Michigan Medical Center in Ann Arbor. This course was designed primarily to further reduce mortality rates in the fields of maternal and child health.

Marshfield Clinic Honored

In celebration of the completion of the addition to the Marshfield Clinic which has dwarfed the original Clinic building and in recognition of the Clinic Staff's work, a dinner sponsored by the Chamber of Commerce and attended by nearly 250 persons was held in February at the Elks Club. Speaking from the rostrum were various city officials, *Dr. Charles Vedder,* President of the Clinic, and *Dr. Karl H. Doege,* Past-president. The Clinic was lauded as a local health asset, as an attraction to new residents and new industries, and for "Making Marshfield Grow."

Attends National Conference

Dr. Albert C. Edwards, City Health Commissioner of Racine and member of the Medical Advisory Committee of the National Foundation, was one of 100 physicians from 14 midwestern states to attend a recent conference in Chicago. The conference was called to discuss plans for a new patient-care program to aid children and adolescents afflicted with rheumatoid arthritis and certain birth defects involving the central nervous system.

Wausau Child Guidance Center Opens

Various civic leaders and representatives of social, law enforcement, school and government groups inspected the new quarters of the Child Guidance Center of Marathon County at a recent open house. The new center, a United Fund agency, is located on the first floor of St. Mary's Hospital in Wausau and is open half days Monday through Friday. *Dr. Carl Kline* is the staff psychiatrist and he is assisted by a social worker and secretary.

At present the center receives its support from the United Fund, patient fees, civic-minded individuals and business institutions. But for adequate and expanded operation involving a staff psychologist, an additional psychiatrist and a full-time program, it will require additional financial support.

It is hoped this center will be the beginning of services in the diagnosis and treatment of emotionally disturbed children.

Dr. Snowden Attends Chicago Course

Dr. Paul W. Snowden of Monroe recently attended a special course in neurological radiology and cardiac catheterization at the Illinois Medical School in Chicago. He also did special work at Children's Hospital in cardiac diagnosis of congenital heart abnormalities, rheumatic fever and heart damages.

Portage Hospital Elects Officers

Dr. R. F. Inman, Montello, was reelected chief of the medical staff at Divine Saviour Hospital in Portage. *Dr. J. J. Saxe* was elected vice-president, *Dr. T. S. Westcott,* secretary-treasurer, and *Dr. W. A. Taylor,* to a three-year term as a member of the executive committee.

Two Additions to Whitehall Clinic

Dr. S. T. Gettelman has announced that *Drs. Ralph S. Hudson* and *J. Birney Dibble* have joined him at the Whitehall Medical Clinic and will hold office hours there on appointment. Both physicians have been coming at Doctor Gettelman's request from Eau Claire for surgery at the Whitehall Community Hospital since last September.

Doctor Hudson was graduated from the University of Illinois and Doctor Dibble from the University of Wisconsin. Both had additional training in Chicago and saw military service as naval surgeons.

Three Physicians Honored

The advisory board at St. Agnes School of Nursing, Fond du Lac, honored three school physicians,

(continued)

Physicians whose names are printed in italic are members of the Society.

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WISCONSIN PHYSICIANS (continued)

Drs. J. C. Yockey, J. S. Huebner, and *John C. McCullough* at a buffet dinner meeting held in January. The director of the nursing school cited the physicians for their services in caring for the health of the many students enrolled in the school.

Doctor Hopkins Joins Algoma Clinic

Dr. Richard Hopkins recently joined *Drs. C. W. Stiehl* and *J. F. March* at the Algoma Clinic following his discharge from military service. Before coming to Algoma, Doctor Hopkins was graduated from the University of Michigan, interned at Madison General Hospital, and practiced at Elk Rapids and Lansing, Michigan.

Wausau Pediatrician Accepts Scholarship

Dr. Warren B. Rudy of Wausau has accepted a scholarship offered by the Wisconsin Valley United Cerebral Palsy Association. This grant will partially finance Doctor Rudy's attendance at a postgraduate course in cerebral palsy to be held in New York shortly.

Melrose Krohn Clinic Open House

During the early part of February an open house was held at the new Krohn Clinic in Melrose. The new building has a large reception room and office, two consultation offices, x-ray department, dark room, drug room and a combination room for optical, laboratory and consultation services.

(continued)

ARTHRITIC PATIENTS WANTED

The University of Wisconsin Medical School is investigating some of the metabolic aspects of rheumatoid arthritis. Dr. John Z. Bowers, Dean, asks for the cooperation of Wisconsin physicians. Doctor Bowers says, "we are anxious to study patients who have active uncomplicated disease and who have not received steroid hormones for two months. About one week of hospitalization would be necessary for the studies or they could be carried out without hospitalization." Doctor Bowers would be happy to discuss the matter with any physicians who have such patients.

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Drs. John Marks, John Krohn, John Noble, and A. T. Laymeyer from the Krohn Clinic in Black River Falls will staff the clinic on appointed days. They will be assisted by a receptionist and nurse.

Blue River Doctor Retires

After 45 years of practice in the Blue River and Boscobel area, *Dr. M. W. Randall* has announced that he will retire from practice. A native of Wisconsin, Doctor Randall graduated from Marquette University School of Medicine and began his first practice at Excelsior in 1914. His immediate retirement plans include a relaxing trip to Texas.

THIRD AND TWELFTH DISTRICTS

On Medical Alumni Program

Dr. Francis M. Forster, Chairman of the Department of Neurology at the University of Wisconsin Medical School, was featured speaker on a program presented at the dinner meeting of the first Wausau session of the Wisconsin Medical Alumni Association. The meeting was held March 3 at the Wausau Club.

Dr. A. C. Albright Speaks

A paper entitled, "Thyroid; Fundamental Considerations," was presented by *Dr. Edwin C. Albright,* Associate Professor of Medicine at the University of Wisconsin, at the 7th Annual Graduate Symposium sponsored by the Institute for Metabolic Research at the Highland—Alameda County Hospital in Oakland, California, on February 16. Doctor Albright was also a participant in a panel on "Recent Advances in Principles and Practice."

Three New Physicians in Madison

The Jackson Clinic and Methodist Hospital, Madison, have announced the addition of three new doctors to their staffs. They are Drs. G. K. Boyd, internist, J. H. Morledge, cardiologist, and Robert Ainslie, otorhinolaryngologist.

Doctor Boyd is a 1951 graduate of the University of Pittsburg. Prior to two years in the U. S. Army he interned at the University of Pittsburgh and, upon release from service, served a residency at the Mayo Foundation, Rochester, Minnesota. He has also received an M.S. degree from the University of Minnesota.

Having recently completed a year as a research fellow in cardiology at the University of Washington School of Medicine, Doctor Morledge's medical background consists of a degree from Western Reserve University School of Medicine, Cleveland, Ohio; an internship at Duke University Hospital, Durham, North Carolina; and service in the U. S. Air Force from 1953 to 1955.

After a year at the Cleveland Clinic, Dr. Robert Ainslie has returned to the staff of the Jackson Clinic in the department of otorhinolaryngology. Previously Doctor Ainslie had been associated with the clinic for four years.

A graduate of the University of Rochester, Doctor Ainslie interned at Jersey City Medical Center. He spent about 10 years in medical missionary work in China and the Philippines and was associated with the Cleveland Clinic for several years before coming to the Jackson Clinic in 1954.

Legislators' Wives Visit UW

On February 17 approximately 120 wives of state legislators visited the University of Wisconsin Hospitals. Staff members who addressed the group and

(continued)

NEW SERVICE FOR PATIENTS WITH CONVULSIVE DISORDER

The University of Wisconsin Hospitals has available to physicians a new service in the diagnosis and treatment of patients with convulsive disorder. Patients will be admitted to the neurology service for a period of study for a week to ten days. It is preferable that patients be admitted to the hospital on Tuesday afternoon or Wednesday morning so that the usual diagnostic studies can be completed prior to the week-end.

The patients who have seizures due to neurosurgical diseases will be seen by the neurosurgical service and transferred to that service for proper surgical treatment. The patients whose seizures require medical therapy will be evaluated and put on the most efficacious medication including the newer drugs and be referred back to their referring physicians with full information regarding medication.

It is hoped that the referring physician will agree that the patients might be seen in follow-up in a special epilepsy clinic at three to six months intervals or oftener if he so desires.—FRANCIS M. FORSTER, M.D., *Chairman, Dept. of Neurology.*

UNIVERSITY OF WISCONSIN HOSPITALS

demonstrated research programs in progress at the University were: *Drs. John Z. Bowers*, Dean of the medical school, *Ben Peckham*, Chairman of Obstetrics and Gynecology, *Edgar Gordon*, Professor of Medicine, and *Robert Schilling*, Associate Professor of Medicine.

Doctor Meyer Talks

"Anticoagulant Therapy" was the topic of a lecture presented by *Dr. O. O. Meyer*, Chairman of the Department of Medicine at the University of Wisconsin. The speech was given in Phoenix, Arizona, while he was Physician-in-Residence at the V. A. Hospital from February 16–18.

Dr. Nathan Smith Lectures

A paper entitled, "Metabolic Relationships in Iron and Protein Metabolism," was given by Dr. Nathan J. Smith at the Pediatric Hematology Club meeting held February 9–11 at Children's Medical Center, Boston, Massachusetts. Doctor Smith is Chairman of the Department of Pediatrics at the University of Wisconsin Medical School.

Doctor Healy Moves to New Office

Dr. W. G. Healy, Madison, has moved into a new two-story office building at 1905 Monroe Street. Doctor Healy occupies a ground floor suite of the 30 by 60-foot brick building.

New Affiliate at Beloit Clinic

Dr. A. O. Tuftee began practice at the Beloit Clinic in January. An orthopedic surgeon, Doctor Tuftee received his medical education at the University of Illinois College of Medicine, interned and served a residency at Cook County Hospital in Chicago, and came to Beloit from Minneapolis, Minnesota, where he was associated with the Shriners' Crippled Children's Hospital.

Participates in Chicago Conference

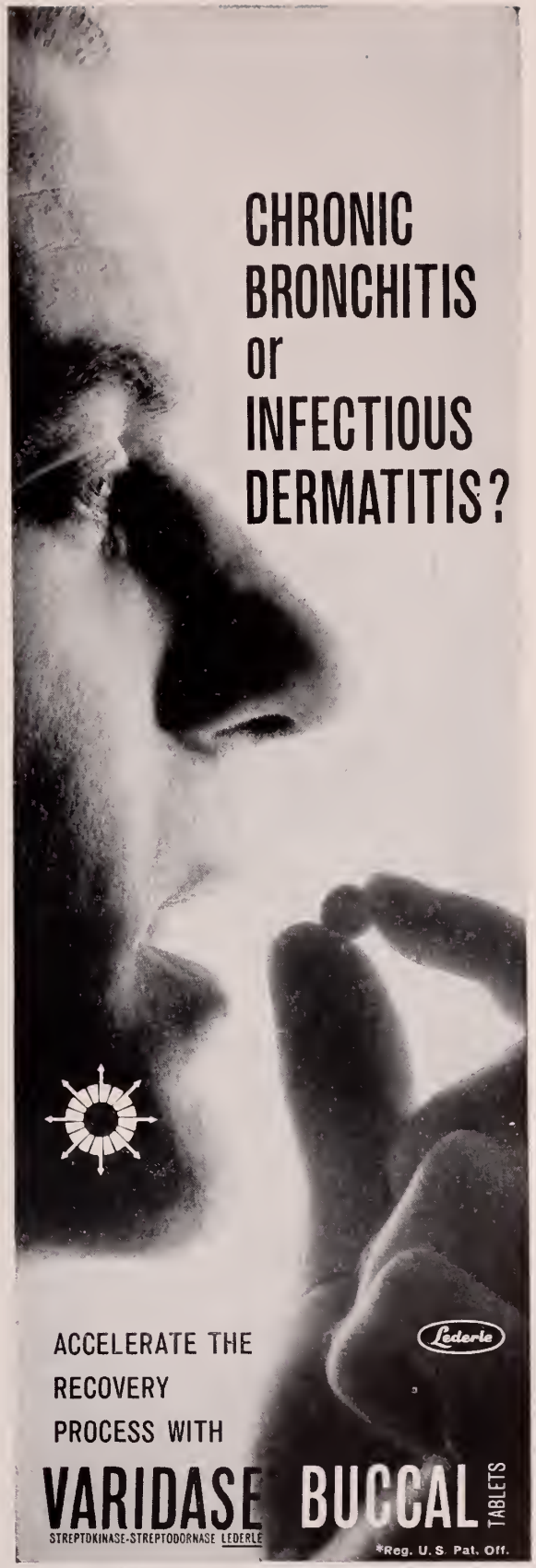
Professor of Radiology at the University of Wisconsin, *Dr. Halvor Vermund*, attended the meeting of the American College of Radiology held recently in Chicago. While there he participated in a workshop on teaching of residents.

Madison Doctors Attend Conference

Two Madison physicians, *Peter A. Duehr* and *Frederick J. Davis*, attended the Eleventh Clinical Conference of the Chicago Ophthalmological Society in Chicago. The meetings were held on February 13 and 14.

Milwaukee Doctor Accepts Post

Dr. Joseph Shaiken of Milwaukee was named president-elect of the American College of Gastroenterology at the organizations annual convention held in New Orleans from October 19–23. Doctor Shaiken presented a report of a study of "Duodenal Ulcer in Children" at the convention.



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SPONTIN IN SERIOUS

A Special Report from Abbott to the Medical Profession on a Year's Clinical Experience with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem — and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

Abbott

What's New at the Medical Schools

Marquette Faculty in Ob–Gyn Meeting

Dr. F. Jackson Stoddard and Dr. F. J. Hofmeister participated in the seventh annual clinical meeting of the American College of Obstetricians and Gynecologists in Atlantic City April 5–8. Both physicians are on the faculty of Marquette University School of Medicine.

Doctor Kimmelstiel Speaks in Japan

Dr. Paul Kimmelstiel, Professor of Pathology at Marquette University School of Medicine and Director of Laboratories at the Milwaukee County Hospital, addressed the fifteenth General Assembly of the Japanese Medical Congress in Tokyo April 1–5. He also addressed the Association of Japanese Pathologists on March 30.

Designs Electromagnetic Flowmeter

A long-term interest in electronics is an important tool in the trade of University of Wisconsin medical scientist, Dr. Francis L. Abel.

The electronics background has paid off for him in the design and assembly of an electromagnetic flowmeter, an instrument used to measure the flow of blood in the body.

The flowmeter operates much like an electric generator. Magnetic lines of force cut by the flowing blood give a measurable quantity—induced electric potential—which is directly proportional to the volume of blood in the vessel.

Electromagnets placed around the vessel set up the magnetic field. Platinum electrodes make contact with the vessel wall, and pick up the differences in potential. These differences when amplified can be recorded.

Doctor Abel, a fellow in the medical school's department of physiology, holds an M.D., and is now at work on a Ph.D. in physiology. Doctor Abel's major professor, Dr. Q. R. Murphy, has worked with him on the instrument, which is somewhat different electronically than three or four electromagnetic flowmeters in existence previously.

The electromagnetic method is regarded by Doctor Abel as the most ideal of a number of ways to measure blood flow. Its chief advantage is that blood flow can be recorded without entering the vessel.

In other indirect systems based on pressure differences, the blood vessel must be opened and the anticoagulant, heparin, added to the blood so that it will not clot.

Rapid response in Doctor Abel's instrument makes it possible to get an instantaneous report on the volume of blood flowing in any vessel, an advantage over indirect methods which average the flow over a period of time. These methods assume a steady rate of flow which at best is an approximation to the actual case.

Another advantage of the electromagnetic instrument is that it avoids possible interruption of the nerve supply.

Electromagnets of varying sizes are being constructed by Doctor Abel to be used in measuring the flow in vessels of different sizes.

The instrument will be extremely useful in measuring blood flow in many areas of the body, according to Doctor Abel.

For instance, it will be able to record the moment to moment variations in the cardiac output from the aorta, the main trunk which supplies the entire arterial system.

It will also measure the flow of blood to the kidneys, and possibly coronary flow-blood flow in the arteries which supply the heart.

One further application in an almost limitless list of possibilities is the determination of the effect of a drug on the pattern of blood flow in various vessels.

$30,000 Grant to UW Medical School

The University of Wisconsin Medical School, Madison, is the recipient of a $30,000 grant from the John and Mary R. Markle Foundation for use by Dr. John Rankin, assistant professor of internal medicine. The grant will be used by Doctor Rankin over a five-year period which started in 1959.

Doctor Rankin is one of 25 physicians, teachers and research workers on the faculties of medical schools in the United States and Canada receiving the appointment of Markle Scholars in Medical Science by the Markle Foundation, New York. Each appointment carries with it a $30,000 grant, appropriated to the medical school where the Scholar will teach and do research, to be used toward his support and to aid his research.

In the twelve years the fund has been making the Scholar grants, over 250 doctors in 74 medical schools in the United States and Canada have been aided with total appropriations of $7,550,000, John M. Russell, executive director and vice-president of the fund, announced. The purpose of the program is "to strengthen medical education by offering academic security and financial help to teachers and investigators in medical schools early in their careers."

Doctor Hofmeister to Show Film

Dr. F. J. Hofmeister showed a film called, "The Complete Office Gynecological Examination," at the Japanese Medical Congress in April, according to an announcement by the American Medical Association. The movie was prepared at Marquette University and Milwaukee Hospital.

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Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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Handling of Narcotic Drugs

Dear Sirs:

The Council on Industrial Health has considered the problems of the handling of narcotic drugs in industrial health services and we have sought the opinion of our Legal Division. The results of the legal opinions and Council discussions may be summarized as follows:

A physician who is duly registered under the Harrison Narcotic Act may maintain a stock of narcotics in an industrial medical department providing that this stock is maintained under lock and key. It is permissible for a nurse, as the physician's duly authorized agent, to have access to the narcotics maintained by the physician for the purpose of dispensing such narcotics to patients of the physician under his specific orders and directions. No other physician is authorized to prescribe from this supply of narcotics which is the responsibility of the physician under whose name the narcotics were acquired.

A nurse has no legal authority on her own to dispense narcotics to a sick or injured workman even in the event of a serious emergency such as a fire. Only a licensed physician who is duly registered under the Harrison Narcotic Act has the authority to prescribe the administration of narcotics covered by the Act. Such authority does not permit the physician to issue standing orders governing the administration of narcotics in the event of an emergency. There must be a physician-patient relationship before the physician may legally prescribe the administration of a narcotic drug.

In the event of an emergency a nurse may telephone the physician and describe to him the nature of the emergency so that the physician in turn may prescribe suitable treatment.

The statement is repeatedly made that "the nurse functions as the eyes, ears, and hands of the physician." If this is true, then the physician should be permitted to prescribe by telephone in the event of an emergency.

A nurse would be in technical violation of the law if, for example, she were to administer morphine to a seriously burned patient without first obtaining the physician's order.

In actual practice it is unquestionably true that narcotics are sometimes administered by nurses in emergency cases when the physician cannot be reached immediately. The physician responsible for the narcotics then fills out the proper forms to satisfy the requirements of the law. While this is a technical violation of the law, we know of no case in which a nurse has become criminally involved because of the administration of narcotics in bona fide emergency situations without the prior order of a physician. In some areas the problem has been solved by titling the occupational health service a plant "hospital." Hospitals, of course, are entitled to maintain stocks of narcotic drugs.

If there are specific examples on which you would like an opinion or questions which have not been answered by the above, please don't hesitate to write us again.

Sincerely yours,
HOWARD N. SCHULZ
Staff Assistant, American Medical Association
535 North Dearborn Street
Chicago 10, Illinois

In Congressional Record

To Editor:

I was especially pleased to note in the February issue of the *Wisconsin Medical Journal* an article regarding the community-wide program held by the Fond du Lac County Medical Society on the new Era of Aging.

It was a pleasure to have this article reprinted in the Congressional Record recently at the same time that I made some comments on the Senate Floor regarding the needs of our Senior Citizens. I am happy to enclose a copy herewith.

I feel that such constructive efforts to meet the problems confronted by our growing percentage of elderly folks deserve to be commended and I appreciate your calling my attention to these activities through your worthwhile publication.

With best wishes I am

Sincerely yours,
ALEXANDER WILEY
United States Senator from Wisconsin

4-H Club Recognition

To State Medical Society:

I am highly pleased with the recognition given our 4-H club by the State Medical Society of Wisconsin. We enjoyed working on our health project last year. This year we will be doing something along the therapy line. For Easter we are going to prepare some boxes filled with fancy cookies for the retarded children of our area. We are going to use the colorful cottage cheese cartons and each family is going to make some cookies with which we will fill the boxes. Maybe later in spring when we have some plants, we'll distribute some potted plants to some other group.

Our April meeting is being devoted entirely to health. I plan to have an outside speaker talk to us about the retarded child. We'll have a demonstration, games, discussions, and maybe a quiz. I am

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CORRESPONDENCE (continued)

looking forward to this meeting, because I think it will be fun as well as instructive.

I shall make good use of the magazine you have awarded us, and I will circulate it among the members. Thank you for your wonderful kindness.

Sincerely yours,

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Medical Meetings - Postgraduate Courses

Wisconsin Trudeau Society

PROGRAM

Spring Meeting *April 25, 1959*

Madison V.A. Hospital

9:45 a.m. Welcome

EINAR R. DANIELS, M.D., President, Wisconsin Trudeau Society

10:00 a.m. Four Year Follow-up of 350 Pulmonary Resections for Tuberculosis

JOHN T. MENDENHALL, M.D., Associate Clinical Professor of Surgery, U. W. Medical School; Chief of Thoracic Surgery, Madison V.A. Hospital

10:20 a.m. Traumatic Rupture of the Bronchus, Surgical Reconstruction of the Bronchus after 13 Years with Recovery of Lung Function.

JOSEPH W. GALE, M.D., Professor of Surgery and Chief of Thoracic Surgery, U. W. Medical School and Hospitals

10:40 a.m. Pulmonary Function in the Immediate Post-thoracotomy Period.

THEODORE C. SMITH, Resident in Anesthesiology, University Hospitals, Madison

11:00 a.m. Coffee Break

11:15 a.m. A Simple Method for Determining Arterial CO_2 Tension

EDNA M. CREE, M.D., Clinical Instructor in Medicine, U. W. Medical School; Director, Pulmonary Function Laboratory, Madison, V.A. Hospital

11:30 a.m. The Use of Pulmonary Function Tests in the Diagnosis and Evaluation of Some Congenital Heart Diseases

JOHN RANKIN, M.D., Assistant Professor of Medicine, U. W. Medical School

11:45 a.m. Unusual Cases of Non-tuberculous Pulmonary Disease. The Role of Surgery in Diagnosis

BENTON C. TAYLOR, M.D., Assistant Clinical Professor of Medicine, U. W. Medical School and Madison V.A. Hospital

and

B. JACK LONGLEY, M.D., Assistant Clinical Professor of Surgery, U. W. Medical School and Madison V.A. Hospital

12:15 p.m. Lunch

1:30 p.m. Alveolar Proteinosis

J. RICHARD JOHNSON, M.D., Assistant Clinical Professor of Medicine, U. W. Medical School and Madison V.A. Hospital Chief of Tuberculosis Service

1:50 p.m. Experiences with the Use of Amphotericin B in the Treatment of Pulmonary and Systemic Mycoses

HELEN A. DICKIE, M.D., Professor of Medicine and Chief of Section of Chest Diseases, U. W. Medical School

2:10 p.m. Anonymous (Atypical) Acid-Fast Bacilli

DONALD W. SMITH, Ph. D., Associate Professor of Medical Microbiology, U. W. Medical School

2:30 p.m. Viral Pneumonitis

JOHN H. FLINN, M.D., Associate Professor and Director, Department of Student Health, U. W. Medical School

2:45 p.m. Coffee Break

3:00 p.m. Q-Fever in Wisconsin

WILLIAM D. STOVALL, M.D., Emeritus Professor of Clinical Pathology and Director, State Laboratory of Hygiene, University of Wisconsin

3:15 p.m. Hyperventilation Syndrome

J. D. KABLER, M.D., Instructor in Medicine, U. W. Medical School

3:30 p.m. The Electrocardiographic Features of Advanced Pulmonary Emphysema

RICHARD H. WASSERBURGER, M.D., Assistant Clinical Professor of Medicine, U. W. Medical School, and Madison V.A. Hospital

3:45 p.m. Cyanosis in the Newborn

GEORGE M. MAXWELL, M.D., Assistant Professor of Pediatrics, U. W. Medical School

4:00 p.m. Adjournment

Exhibits: John H. Juhl, Associate Professor of Radiology, U. W. Medical School

5:00 p.m. Cocktail Party

6:30 p.m. Dinner

President's Address: *What Can the Trudeau Society Do to Serve the Physicians and Health Services of the State of Wisconsin?"*

EINAR R. DANIELS, M.D., Milwaukee

(continued)

PLAN NOW TO ATTEND THE

108th ANNUAL MEETING *OF THE* AMERICAN MEDICAL ASSOCIATION

June 8-12, 1959, Atlantic City, New Jersey

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Childbirth featured in largest combined session ever offered by A.M.A. Seven sections—Obstetrics and Gynecology; Anesthesiology; Pediatrics; Preventive Medicine; General Practice; Diseases of the Chest and Nervous and Mental Diseases present a morning long symposium.

Liver diseases presented in a combined symposium and panel session with six sections participating: Internal Medicine, General Practice, Experimental Medicine and Therapeutics, Pathology, Radiology and Gastroenterology.

Typical of the hundreds of speakers and topics scheduled for presentation:

SYMPOSIUM ON HEPATIC DISEASES

"Newer Concepts of Bilirubin Metabolism"
David Schachter, New York City, New York

"Hepatic Coma: Its Physiologic and Chemical Basis"
S. P. Bessman, Baltimore, Maryland

"Current Problems in Hepatic Pathology"
I. N. Dubin, Philadelphia, Pennsylvania

"Current Knowledge of Viral Hepatitis"
Joseph Stokes, Jr., Philadelphia, Pennsylvania

"Radiography in the Diagnosis of Hepatic Disease"
John R. Hodgson, Rochester, Minnesota

"Newer Concepts of Cirrhosis"
Gerald Klatskin, New Haven, Connecticut

PANEL DISCUSSION ON HEPATIC DISEASES

Moderator—Cecil Watson, Minneapolis, Minnesota

Atlantic City is an ideal family playground. The fabulous Boardwalk and world renowned Steel Pier are focal points of interest at this famous ocean side resort.

For advance hotel and meeting registration information write: Convention Services, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois

Jackson Clinic Postgraduate Program

The Jackson Clinic is presenting a postgraduate program on May 28. There will be a luncheon at 12:30 p.m., and the meeting will start at 1:30 p.m. There will be a social hour from 5:30 to 6:30 p.m. At the dinner at 6:30 p.m., Arnold Jackson, M.D., will give an illustrated talk on his recent trip around the world with the International College of Surgeons.

The following clinic physicians will present papers: Etheldred L. Schafer, M.D., James W. Messer, M.D., J. Donald Hare, M.D., Gordon F. Schumacher, M.D., George K. Boyd, M.D., and John H. Morledge, M.D.

Physicians interested in attending may make a reservation now with John R. Steeper, M.D., Chairman, 30 South Henry Street, Madison.

Refresher Course on Anesthesia

A refresher course on anesthesia and a symposium of cardiac arrest has been scheduled at St. Francis hospital, La Crosse, Wis., for May 16.

Sponsored by the Wisconsin Heart Association as part of its professional education program, the one-day course is open to all anesthetists, physicians, operating room supervisors and hospital administrators from western Wisconsin and eastern Minnesota.

The course discussion will include causes and prevention of cardiac arrest; postoperative management of cardiac arrest; recent advances in anesthesia, and new drugs.

Registration for the course will begin at 9 a.m. Those planning to attend the course are asked to contact Wisconsin Heart Association, 205 West Highland Avenue, Milwaukee 3, to obtain additional information and reservations.

State Medical Assistants' Meeting

The Wisconsin State Medical Assistants Society will meet at Eau Claire on June 5, 6 and 7 for the annual session. The meeting will be held at the Eau Claire Hotel. Opening the three-day session will be the president's conference on Friday evening, June 5, at 8:00 o'clock. An educational program and a tour of the Northern Colony is scheduled for all day Saturday, June 6. On Sunday morning, June 7, there will be the annual business meeting with election of officers.

Registration fee is $14.00. For further information contact: Violet M. Owen, President, 1922 University Avenue, Madison, Wisconsin. A complete program will appear in the May issue of the *Wisconsin Medical Journal.*

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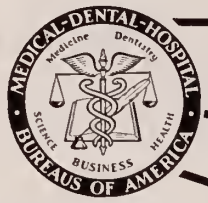

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Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.
Preston W. Thomas, M. D.

MEDICAL MEETINGS (continued)

North Shore Hospital Lecture

The eighth lecture in the Ninth Annual North Shore Hospital Lecture Series on "Emotional Forces in the Family" will be held at the hospital, 225 Sheridan Road, Winnetka, Illinois, on Wednesday, May 6, at 8:00 p.m. "The Individual, the Family, and the Boss" will be discussed by Bertram Schaffner, M.D., Psychoanalyst, New York City.

University of Minnesota Courses

Medical continuation courses to be presented at the Center for Continuation Study, University of Minnesota, are as follows:

May 11–15: Introduction to Electrocardiography for General Physicians

May 18–22: Proctology for General Physicians

May 27–29: Otolaryngology for Specialists

June 15–17: Gynecology for General Physicians

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minn.

National Tuberculosis Association

The annual meeting of the National Tuberculosis Association and its medical section, the American Trudeau Society, will be held May 25–28 at the Palmer House in Chicago.

Six Wisconsin men will participate in the program. On Monday morning, May 25, starting at 10:05 o'clock the subject, "The Influence of Increased Intra-alveolar Pressure on the Uptake of Carbon Monoxide by the Lungs and on the Diffusing Capacity of the Pulmonary Membrane and Pulmonary Capillary Volume in Man," will be discussed by Theodore C. Smith, M.D., John H. Ramlo, D.D.S., Richard A. Cooper, B.S., Carl B. Weston, B.S., and John Rankin, M.D., of Madison.

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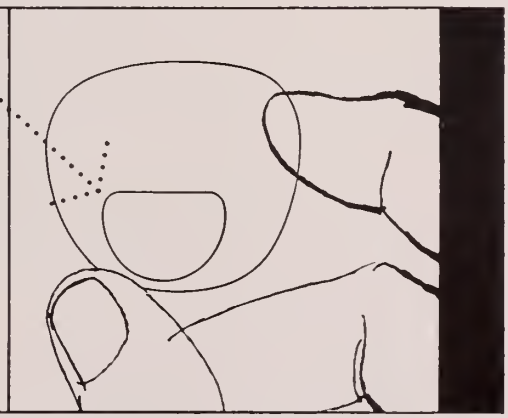

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MEDICAL MEETINGS (continued)

E. Dale Trout, D.Sc., Milwaukee, will have a "Radiation Protection Demonstration" in conjunction with the joint public health and nursing session starting at 2:00 p.m. Monday, May 25.

For further information contact Agnes Fahy, National Tuberculosis Association, 1790 Broadway, New York 19, N. Y., or telephone CIrcle 5–8000, Extension 189.

University of Pennsylvania Courses

A Series of Short Refresher Courses will be given during May and June 1959, by the Children's Hospital of Philadelphia and by the Graduate School of Medicine, University of Pennsylvania.

Inquiries should be addressed to Irving J. Wolman, M.D., Director of Postgraduate Education, The Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia 46, Pa.

Conference at Mount Sinai Hospital

Mount Sinai Hospital, Milwaukee, invites all members of the State Medical Society of Wisconsin to attend the annual Spring Medical Conference to be held on Thursday morning, May 21, in the hospital auditorium. The distinguished guest speaker will be Dr. Edith L. Potter, investigator, teacher, and author, whose subject will be "Diseases of the Newborn." Doctor Potter is associate professor of pathology at the University of Chicago, pathologist to the Chicago Lying-in Hospital, pathologist in chief to the Chicago Health Department, and consultant to the Armed Forces Institute of Pathology and Walter Reed Medical Center. She has been the recipient of three distinguished awards for achievement, five degrees from the University of Minnesota, and honorary degrees from foreign and American universities. Her publications number 75 in worldwide medical journals.

(continued)

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MEDICAL MEETINGS (continued)

A.M.A. Annual Meeting

Some 15,000 physicians will gather in Atlantic City, N. J., June 8–12 for the 108th annual meeting of the American Medical Association.

Besides physicians, the meeting will be attended by residents, interns, nurses, technicians, students, and physicians' wives and members of their families.

The House of Delegates will meet throughout the week in the Traymore Hotel, headquarters for the meeting. The 20 scientific sections of the A.M.A. and five government medical services will also be represented in the House.

First order of business for the House will be the selection of a physician to receive one of medicine's highest honors—the Distinguished Service Award. He will be elected from three persons, whose names are submitted by the Board of Trustees. Nominees are screened by the Board from names submitted by the general membership.

The opening session will be addressed by Dr. Gunnar Gundersen, La Crosse, Wis., outgoing president, and his successor, Dr. Louis M. Orr, Orlando, Fla.

A president-elect to serve one year and be inaugurated as president in 1960 will be elected during the meeting.

For the fourth year, high school students who have won special A.M.A. awards in the National Science Fair will show their prize-winning work at the scientific exhibit.

The annual film program will be highlighted by the presentation of 60 medical motion pictures.

The Woman's Auxiliary to the A.M.A. will hold its meeting Tuesday through Thursday. Representatives of the 75,000 members—all doctors' wives—will discuss their program in sessions at the Chalfonte-Haddon Hall.

Other sidelights of the meeting will be the special art exhibits including that of the American Physician's Art Association, and the 43rd annual American Medical Golfing Association tournament.

For advance hotel and meeting registration information, contact the Convention Services Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Trudeau School of Tuberculosis

The Trudeau School of Tuberculosis and Other Pulmonary Diseases, which will hold its forty-fourth session in Saranac Lake, N. Y., from June 8 to 26 continues to provide a unique opportunity for training in the field of chest diseases. This annual postgraduate course, conducted under the auspices of the Trudeau Foundation and supported by the Hyde

(continued)

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Foundation, is able to provide outstanding instruction at a minimal tuition of $100.00 for a three weeks' session. Attendance at the Trudeau School carries with it a thorough review for specialization in pulmonary disease or for work in public health involving tuberculosis.

Approximately half of the time is devoted to tuberculosis and the other half divided between such subjects as silicosis, pulmonary fibrosis, emphysema, fungus infection, sarcoidosis, pneumonias and intrathoracic tumors.

The enrollment is necessarily limited and therefore applications should be made early. A few scholarships are available for those who qualify.

Inquiries should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 500, Saranac Lake, N. Y.

Nutrition Meeting of AMA Council

Heart disease and disorders of nutrient absorption will be discussed at a Symposium on Nutritional Problems in Medicine May 8 in Nashville, Tenn. The one-day symposium is being sponsored by the American Medical Association's Council on Foods and Nutrition and the Vanderbilt University Medical School.

(continued)

Convenient information for physicians starting diabetic patients on

DIABINESE

simple once-a-day dosage in practice

During the initial control period, the patient should check his urine at frequent intervals, and report at least once weekly for review of symptoms, physical examination, urine and/or blood examination for glucose.

The New Patient *(no previous antidiabetic therapy)*

1. Initial daily dose 500 mg. (2 tablets of 250 mg. each) with breakfast.

2. In elderly patients, initial dose 250 mg. (1 tablet) daily.

3. CONTROL PERIOD

(a) If blood sugar reaches normal levels after three to seven days, or if glycosuria disappears, lower daily dose of 500 mg. to a level between 250 mg. (1 tablet) and 375 mg. (1½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage may be reduced to as low as 100 mg.

(b) If hyperglycemia or glycosuria persists or develops, increase the daily dose from 500 mg. to 625 mg. (2½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage should be increased from 250 mg. according to patient response.

(c) Continue weekly adjustments during first month of therapy until maintenance dose has been established. Adjustments below 250 mg. daily are best made in steps of 100 mg. (one 100 mg. tablet). The maintenance dose may occasionally be as low as 100 mg. (one 100 mg. tablet daily) or, rarely, as high as 1.0 Gm. (four 250 mg. tablets) daily. Do not exceed daily dose of 1.0 Gm.

Transfer of Patient from Insulin

1. If patient is taking 40 or less units of insulin daily and gives no history of severe or "brittle" diabetic response, discontinue insulin and replace with DIABINESE as in The New Patient.

2. Complete control period as for The New Patient. Priming ("loading") doses should not be used.

3. If patient is taking more than 40 units of insulin daily, or shows evidence of severe or brittle diabetes, reduce insulin dose by 50 per cent and initiate DIABINESE therapy as for The New Patient. Further reduction of insulin dosage depends on patient response.

Transfer of Patient from Other Oral Medication

Where less than satisfactory control has been achieved with other oral medication, or where a change to once-a-day dosage is desired, DIABINESE may be successfully substituted. Such a transfer may be made by discontinuing previous oral medication, substituting DIABINESE, and continuing control period as for The New Patient. Avoid priming doses.

The clinical safety of DIABINESE has been established by more than two years' trial. By adherence to the above dosage schedule, side effects of DIABINESE will generally be infrequent, mild, and transient.

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International College of Surgeons

The International College of Surgeons will conduct a midsummer postgraduate tour. Dr. Ross T. McIntire, executive director, will be the coordinator.

Countries to be visited are The Netherlands, Denmark, Norway, Sweden, Finland, Russia, Austria, Germany, and France. Departures will be from New York July 17 on the S.S. Nieuw Amsterdam or by plane July 24.

Tour participants will take in the Amsterdam meeting of the I.C.S., July 25–26, and the Helsinki meeting, August 8–9; spend three days in Leningrad, August 11–13, and three days in Moscow, August 15–17; and meet with the fellows of the I.C.S. in Vienna, August 19–20.

Plane passengers will return to New York on August 27 and boat passengers will arrive September 2.

For further information, write to Dr. Ross T. McIntire, executive director, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill., or the International Travel Service, Inc., 119 South State Street, Chicago 3, Ill.

American College of Physicians

The following postgraduate courses will be presented by the American College of Physicians:

May 22–24: "Cardiac Arrhythmias". Philadelphia General Hospital, Philadelphia, Pa. Director: Samuel Bellet, M.D., F.A.C.P.

June 1–5: "Psychiatry for the Internist". Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. Director: Leo H. Bartemeier, M.D., F.A.C.P.

June 15–19: "Special Topics in Internal Medicine." University of Colorado School of Medicine, 4200 East 9th Avenue, Denver, Colo. Co-directors: Gordon Meiklejohn, M.D., F.A.C.P., and C. Wesley Eisele, M.D., F.A.C.P.

June 22–26: "Internal Medicine: Selected Topics." University of Cincinnati College of Medicine, Cincinnati, Ohio. Director: Richard W. Vilter, M.D., F.A.C.P.

For further particulars write: The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

Postgraduate Course in Honolulu

The University of Southern California School of Medicine will hold a postgraduate refresher course in Honolulu and on board the S. S. Lurline from July 29 through August 15. The course is set up so that the physician may elect to attend one of several programs. In addition to lectures, there will be workshops in ECG and X-ray diagnosis as well as Water and Electrolyte Balance and the diagnosis of jaundice. Emphasis is placed on practical diagnosis and therapy.

The group will depart from Los Angeles via United Air Lines July 29 and return to Los Angeles August 15 on the S. S. Lurline. As a time and money saver, physicians may elect to return by air arriving in Los Angeles August 11. Afternoons, evenings and weekends are free so that the participating physicians and their families may enjoy the recreational facilities of the Island.

For further information contact: Director, Postgraduate Division, U.S.C. School of Medicine, 2025 Zonal Avenue, Los Angeles 33, California.

American Board of Obstetrics and Gynecology

The next scheduled examinations (Part II), oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Ill., by the entire Board from May 8 through 19. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I Examination will be notified of their eligibility for the Part II Examinations as soon as possible.

The deadline date for the receipt of new and reopened applications for the 1960 examinations is August 1, 1959. Candidates may submit their applications at any time before that date.

For further information: Robert L. Faulkner, M.D., Secretary-Treasurer, 2105 Adelbert Road, Cleveland 6, Ohio.

UW Postgraduate Course

A postgraduate course, "Pathology and Radiology of the Skeletal System," will be held May 21, 22, 23, at the Wisconsin Center Building, by the University of Wisconsin Medical School. The program will be of special interest to radiologists, pathologists, orthopedic surgeons, pediatricians and others.

The program will consist of formal talks by guest speakers, open discussion and panels for the discussion of cases of unusual interest.

Guest speakers include: Dr. Louis Lichtenstein, chief pathologist, Veterans Administration Center, Los Angeles, Calif.; Dr. E. B. C. Neuhauser, radiologist in chief, Children's Medical Center, Boston, Mass.; Dr. David G. Pugh, Department of Roentgenology, Mayo Clinic, Rochester, Minn.; and Dr. H. J. Spjut, associate professor of surgical pathology, Washington University, St. Louis, Mo.

Members of the UW faculty include: Drs. E. C. Albright, D. M. Angevine, J. R. Cameron, E. S. Gordon, W. H. Jaeschke, J. H. Juhl, J. J. Lalich, C. C. Lobeck, L. W. Paul, and H. W. Wirka.

For further information contact: Dr. Robert C. Parkin, Coordinator of Graduate Medical Education, 418 N. Randall Ave., Madison, 6, Wisconsin.

NEW MEMBERS

R. L. Holder, Krohn Clinic, Black River Falls.

J. G. Webster, 601 Reed Avenue, Manitowoc.

J. D. Hare, 30 South Henry Street, Madison.

R. F. Novak, 310 South Mills Street, Madison.

D. J. McGrath, 1300 University Avenue, Madison.

D. A. Crippen, Red Cedar Clinic, Menomonie.

J. L. Craig, 101 North Main Avenue, New Richmond.

G. V. Martin, 1808 Grand Avenue, Wausau.

W. J. Smollen, 720 Main Street, Racine.

R. C. Ahlbrand, 480 East Grand Avenue, Wisconsin Rapids.

F. L. Ziehl, 161 West Wisconsin Avenue, Milwaukee.

W. E. Reifenrath, 2372-A North 72nd Street, Wauwatosa.

D. R. Burke, 4720 West Layton Avenue, Milwaukee.

N. L. Bugarin, 620 North 19th Street, Milwaukee.

P. J. McNamara, 720 North Jefferson Street, Milwaukee.

R. J. Nickels, V. A. Hospital, Wood.

J. C. Ellis, Jr., 1344 Fitchburg Street, Madison.

G. C. Mathews, 504 West Grand Avenue, Beloit.

Jack Strong, Mauston Clinic, Mauston.

J. C. Payne, 1622 Jackson Street, Oshkosh.

D. L. Werner, 425 Jefferson Street, Burlington.

B. L. Gargas, 808 Third Street, Wausau.

J. E. Foderick, Board of Trade Building, Room 324, Superior.

CHANGES OF ADDRESS

D. W. Barrow, Milwaukee, to 2425 Geary Boulevard, San Francisco 15, California.

H. I. Singer, Milwaukee, to 2091–26th Street, Santa Monica, California.

J. I. Sanders, Quincy, Massachusetts, to 26 Fideles Way, Apartment 629, Brighton 35, Massachusetts.

A. A. Pleyte, Milwaukee, to % Middle River Sanitarium and Hospital, Hawthorne, Wisconsin.

T. F. McCormick, Wood, to 3800 North Oakland Avenue, Milwaukee.

H. M. Bachhuber, Winnebago, to 1200 West Cedar, Cherokee, Iowa.

H. A. Devine, Minocqua, to 630 Grace Avenue, Fond du Lac.

N. H. Schulz, Randolph, to 317 East Lake Street, Horicon.

C. W. Schmidt, Kansas City, Kansas, to 233 South Street, Waukesha.

F. A. Brei, Oshkosh, to 601 West Pershing Street, Appleton.

L. B. McCable, ** Ft. Sam Houston, Texas, to Second General Hospital, Landsthal, Germany, APO 180, New York, New York.

P. J. Murphy, Arcadia, to V. A. Hospital, Tomah.

J. E. Schlichting, Milwaukee, to 612 Huron Avenue, Sheboygan.

R. J. Gardner, Menomonie, to 1218 West Jarvis Avenue, Chicago 26, Illinois.

C. G. McGaughey, Beloit, to 2500 Overlook Terrace, Madison.

L. O. Furr, River Falls, to 624 Somerset Road, New Richmond.

W. J. Bleckwenn, Madison, to Park Lane, P. O. Box 581, Lake Alfred, Florida.

D. P. Davis, Fatehgarh, U. P., India, to Christian Medical College, Vellore, N.A., South India.

G. A. Quinn, ** Milwaukee, to 5320 C Tinker Street, Otis Air Force Base, Massachusetts

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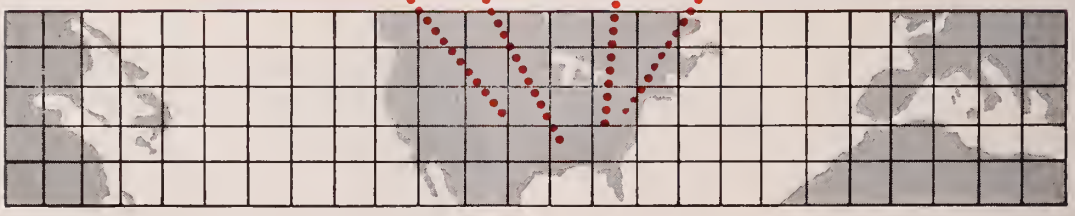

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For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Obituaries

Dr. Anthony Voskuil, a former Cedar Grove practitioner, died September 15 at Santa Barbara, California, where he had lived since his retirement in 1954. He was 81 years of age.

A graduate of Milwaukee Medical College in 1907, he practiced in Sheboygan Falls for two years before locating in Cedar Grove. Preceding his medical education Doctor Voskuil taught in East Dostburg and Armsterdam schools. In 1940 he was among three Cedar Grove doctors honored at a community picnic.

Previously he was a member of the State Medical Society of Wisconsin, the Sheboygan County Medical Society, and the American Medical Association.

Immediate survivors include his widow and a son.

Dr. H. M. Walker of Dodgeville died November 21 after a long illness. He was 57 years of age.

A native of Wisconsin, Doctor Walker was born in Green County in 1901. He received his medical education at Rush Medical College, graduating in 1927. Upon completion of a one-year internship at St. Mary's Hospital, Madison, he opened his Dodgeville office for the general practice of medicine. He was on the staffs of two Dodgeville hospitals, St. Joseph's and Dodgeville General, and was city health officer and clerk of the school board at the time of his death.

Doctor Walker was a member of the State Medical Society of Wisconsin, the Iowa County Medical Society, and the American Medical Association.

He is survived by his widow, Gladys; a daughter, Mrs. Eleanor Maxwell of Dodgeville; and a son, Robert of Madison.

Dr. A. F. Slaney, 66, an Oconto physician for 23 years, died December 19. He had been ill for several months.

Doctor Slaney was born in Richland County in 1892 and graduated from medical school at Loyola in 1918. Following an internship at St. Bernard's Hospital, Chicago, he spent his first years of practice at Hilpert and Stockbridge, moving to Oconto in 1936. He was on the staff of the Oconto Hospital, served as City Health Officer, and was an examiner for several insurance companies. During World War II he served as lieutenant commander in the U. S. Navy Medical Corps.

He was a member of the State Medical Society of Wisconsin, the American Medical Association, and the Oconto County Medical Society, for which he had held the office of secretary-treasurer.

Survivors include his widow, Anna; two daughters, Mrs. Margaret Jaekels, Shorewood, and Mary Ann, Oconto; a physician brother; and three sisters.

Dr. W. J. Winnemann, Milwaukee, succumbed December 20 at the age of 71.

A native of Milwaukee, he spent virtually his entire life there. Doctor Winnemann was born in 1887, graduated from the Wisconsin College of Physicians and Surgeons in 1912, interned at Milwaukee County Hospital, and began practice in Milwaukee in 1914. He served in the U. S. Army during World War I.

For a number of years he was a member of the State Medical Society of Wisconsin, The Medical Society of Milwaukee County, and the American Medical Association.

Doctor Winnemann is survived by his widow and a daughter.

Dr. R. F. Lamb, a Kimberly–Clark physician and surgeon from 1948 to 1954, died in a plane crash on December 23 at the age of 36.

He was born in 1922 and graduated from Northwestern University in 1946. Following the six years he was in Niagara, Doctor Lamb served in the U. S. Army and later settled at Casa Grande, Arizona, where he was associated with a clinic.

While in Wisconsin, Doctor Lamb was a member of the State Medical Society of Wisconsin, the Marinette–Florence County Medical Society, and the American Medical Association.

Four sons survive. His wife and two youngest children were also killed in the accident.

Dr. Will Young passed away January 12 at the age of 75. He was a retired Fort Atkinson physician.

He was born at Elkhorn in 1883. Doctor Young received his medical degree from Northwestern University in 1911, and interned at Washington Boulevard Hospital in Chicago. He first practiced at Bovill, Idaho, as a physician for the Northwestern Railroad and while there built a hospital for the company. Before moving to Fort Atkinson in 1914, he returned to Chicago for further studies in surgery.

Active in many ways, Doctor Young taught Red Cross first aid in his community before and during World War II, served on the city council, and managed the Fort Atkinson baseball team for many years.

Doctor Young was a member of the State Medical Society of Wisconsin, the Jefferson County Medical Society, and the American Medical Association.

He is survived by his widow, Linn; one daughter, Mrs. O. H. Hanson, Fort Atkinson; and a son, Will, Madison.

Dr. Arthur W. Johnson, a Milwaukee proctologist, passed away January 23 following a lingering illness. He was 69 years of age.

Born in Oak Leaf, Ontario, in 1889, Doctor Johnson graduated from Queens University in 1913. The same year he came to Milwaukee to serve an internship at Milwaukee Hospital. Doctor Johnson served in the Canadian Army during World War I, returning to Milwaukee in 1920 to establish his practice.

(continued)

OBITUARIES (continued)

Ill health forced him into retirement two years ago.

Memberships held by Doctor Johnson included those with the State Medical Society of Wisconsin, The Medical Society of Milwaukee County, the American Medical Association, the Academy of Medicine, and the American College of Surgeons.

Immediate survivors include his widow, Emma; a daughter, Mrs. Patricia Fleming, Oakville, Ontario; and a son, Arthur W., Jr., Denver, Colorado.

Dr. W. A. Pease, 82, passed away January 24. He was a retired Rio physician.

He was born in Columbia County in 1876, graduated from the Wisconsin College of Physicians and Surgeons in 1902, and practiced in Rio for 55 years before entering retirement. Prior to entering the medical profession he taught for two years.

While in active practice, Doctor Pease was a member of the State Medical Society of Wisconsin, the Columbia–Marquette–Adams County Medical Society, and the American Medical Association. In 1952 he was granted membership in the State Society's Fifty Year Club.

A sister, Mrs. Mabel Morrison, Waterloo, survives.

Dr. N. J. Wegmann, a Milwaukee surgeon, died February 1 at the age of 58.

He was born at Oshkosh in 1900 and received a medical degree from Marquette University in 1926. Prior to establishing his Milwaukee practice, Doctor Wegmann interned at Madison General Hospital, Madison, and was located for one year at Two Rivers. 1946 to 1956 he held the position of associate professor of anatomy at Marquette. A month preceding his death, Doctor Wegmann had closed his office and moved to Pompano Beach, Florida.

During his years of practice, Doctor Wegmann had been president of the staff and chief of surgery at Misericordia Hospital and was on the staff of Deaconess Hospital.

Medical Society affiliations included those with the State Medical Society, The Medical Society of Milwaukee County, the American Medical Association, the Milwaukee Academy of Medicine, and a fellow of the American College of Surgeons. Active in his county society, he was a member of the board of directors from 1953–1958, and had served in the offices of president and delegate.

Doctor Wegmann is survived by his widow, Grace; five sons, G. William, D.D.S., Fort Lauderdale, Florida; Norbert, Jr., Peter and Tad, all of Milwaukee; and a daughter, Mrs. William Fox, Milwaukee.

Dr. F. E. Darling, Sr., a Milwaukee physician and surgeon for 56 years, died unexpectedly February 13 at the age of 79.

He was born in 1880 at Brodhead. Upon graduation from the Wisconsin College of Physicians and

(continued)

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Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate	1/15 U.S.P. Oral Unit
Thiamine Mononitrate (B_1)	5 mg.
Riboflavin (B_2)	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.
Ca Pantothenate	5 mg.
Choline Bitartrate	50 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
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OBITUARIES (continued)

Surgeons in 1903, he served a preceptorship-type internship at St. Joseph's Hospital, Milwaukee. During his years of practice in Milwaukee he was on the surgical staff of St. Joseph's Hospital, having been the first lecturer in that hospital's school of nursing, was consulting surgeon at St. Michael's Hospital; St. Joseph's Hospital, Hartford; St. Joseph's Hospital, West Bend; and St. Alphonsus' Hospital, Port Washington; and was assistant commissioner of health for the city of Milwaukee. He also was professor of bacteriology at the Wisconsin College of Physicians and Surgeons for a number of years. Doctor Darling served as a major in the U. S. Army in France during World War I.

He practiced for many years with his late brother, Dr. William Darling, and, at the time of his death, was in partnership with a son, Dr. Sylvester Darling.

Doctor Darling was a member of the State Medical Society of Wisconsin, The Medical Society of Milwaukee County, and the American Medical Association.

Surviving are his widow, Mayme; two physician sons, Frank E., Jr., and Sylvester, both of Milwaukee; and a daughter, Mrs. Walter Bendfelt, Jr., Bayside.

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ASHLAND–BAYFIELD–IRON

The Ashland–Bayfield–Iron County Medical Society met February 25 for a dinner meeting at the Platter in Ashland. During the scientific program *Dr. C. M. Ihle*, an orthopedic surgeon from Eau Claire, spoke on hip diseases from infancy to adult life. His talk was supplemented with x-rays.

The business session included the reading of a letter from Congressman A. E. O'Konski pertaining to a bill he sponsored in Congress to include the medical profession in the social security, and the reading of a letter from *Dr. Ernest Strakosch* regarding the special President's Advisory Committee to study the Constitution, Bylaws, Structure and Administration of the State Medical Society. *Dr. Harry Larson* discussed the proposed Red Cross blood bank for Ashland County and proposed that a letter be written to the Minnesota Regional Office favoring such a project.

The 22 members present unanimously reelected the present officers for the coming year.

BROWN

On April 9 the Brown County Medical Society met at the Elks Club in Green Bay. "Surgical Diseases of the Pancreas" was the subject of the lecture given by *Dr. Edwin Ellison*. Doctor Ellison heads the department of surgery at Marquette University School of Medicine.

CLARK

The Memorial Hospital at Neillsville was the site of the meeting of the Clark County Medical Society on December 17. Speaker for the meeting was Assemblyman Frank Nikolai.

During the business session the following officers were chosen:

President—*R. L. Hansen*
Secretary–Treasurer—*George Nemec*
Delegate—*M. V. Overman*
Alternate Delegate—*J. W. Johnson*

DOOR–KEWAUNEE

Dr. H. J. Kief, Fond du Lac, read the Sixth District Councilor Report from the State Medical Society at the February 24th meeting of the Door–Kewaunee County Medical Society. The members met at the Stebbins Hotel in Algoma.

(continued)

Physicians whose names appear in italic are members of the Society.

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fast, effective and long-lasting relief from:

sunburn
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insect bites
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and abrasions

The water-soluble, nonstaining base melts on contact with the tissue, releasing the Xylocaine for immediate anesthetic action. It does not interfere with the healing processes.

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(brand of lidocaine*)
OINTMENT 2.5% & 5%

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carries your patients through the middle of the night

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Warning: May be habit forming

Mephenesin .....425 mg.
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Dosage: One or two tablets ½ hour before retiring.

about waking up at 2 A.M.

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timed-release action for a full night's sleep

NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephenesin in a timed-release tablet. Rapid-acting mephenesin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephenesin is capable of producing sleep,[1] and when combined with a barbiturate enhances barbiturate action.[2,3] Moreover, the integrated action of the two components permits smaller dosages of each,[4] assuring your patients refreshed awakenings without "morning hangover."

1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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FOND DU LAC

The Fond du Lac County Medical Society met March 18 at the Elks Club in Fond du Lac. A paper entitled, "Fractures About the Ankle," was presented by *Dr. Herman W. Wirka* of Madison.

The group voted to discontinue the Clinic for Handicapped Children because it felt that enough orthopedic consultation was available at all times. Also on the agenda of business was the appointment of a committee to study and possibly revise the constitution and bylaws of the county society and the naming of representatives to the Polio Committee. The secretary, *Dr. P. C. Dietz*, reported that letters and telegrams were sent to state and national representatives and senators regarding certain medical legislative bills.

GRANT

The election of officers was the main item of business at the February 5th meeting of the Grant County Medical Society which met at the Lancaster Memorial Hospital. Those named were: *Drs. Herman Rosmann*, president; *Ernest Freymiller*, vice-president; *H. W. Carey*, secretary-treasurer and Delegate; and *Dr. Charles Steidinger*, alternate delegate.

Three specialists from the Jackson Clinic, Madison, an obstetrician, an internist, and a surgeon, comprised a scientific panel for the program.

JEFFERSON

Current changes in the medical school were discussed by *Dr. John Z. Bowers*, Dean of the University of Wisconsin Medical School, at the March 19th meeting of the Jefferson County Medical Society held at the Jefferson Country Club. Twenty members were present.

(continued)

Provide complete patient satisfaction . . .

Prescribe year-round eye protection and comfort from outdoor glare!

More of your patient's time is being spent in out-of-doors activities than ever before.

To better enjoy these activities, their eyes need and deserve the best possible protection from the direct rays of the sun and from the myriads of bright outdoor reflections.

Doctors who are aware of this vital need consider it their responsibility to provide the utmost in glare protection — and prescribe outdoor glasses as one of their regular professional services.

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MARATHON

The Marathon County Medical Society met February 26th for a dinner meeting. During the meeting the members unanimously approved the Wausau City Health Department's simplifications made on the clerical paper forms used in the immunizations given each month at the City Health and Welfare Building. The immunization program received praise from the group.

OUTAGAMIE

On March 19th the members of the Outagamie County Medical Society heard details about the cancer diagnosis facilities which were opened in April. Members of the Cytology Committee and the Outagamie county unit of the American Cancer Society are working jointly on the facilities, which are the only ones in Wisconsin in a city the size of Appleton.

Pictured above discussing the cancer diagnosis facilities in Outagamie county are, left to right: Dr. H. T. Gross, society president; Dr. George Savage, member of the cytology committee; and Dr. Frank Wright, Outagamie county unit of the American Cancer Society.

PIERCE–ST. CROIX

Members of the Pierce–St. Croix County Medical Society met as guests of *Dr. J. E. Newton* on February 17 at the Dibbo Hotel in Hudson to hear Dr. E. H. Juers, Red Wing, Minnesota, speak on "Low Back Syndrome." Following the talk *Drs. F. B. Klaas, P. S. Haskins,* and *J. P. Healy* led a discussion on the subject. Also on the program was Mr. Thomas J. Snidkatus, of the Wisconsin Heart Association, who spoke on the Heart Clinic.

Officers elected during the meeting were:

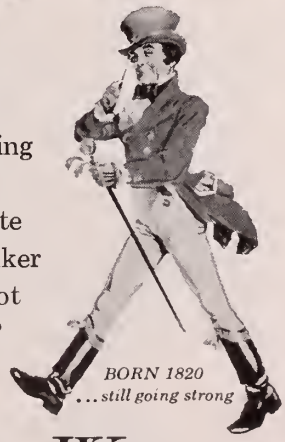
President—*R. R. Davis*

Vice-President—*F. O. Grassl*

Secretary-Treasurer—*P. H. Gutzler*

Always in Good Taste!

Generations of skill in the art of whisky making are reflected in the good taste of Johnnie Walker Scotch. Why not try some soon?



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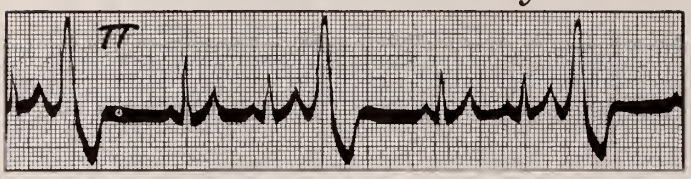
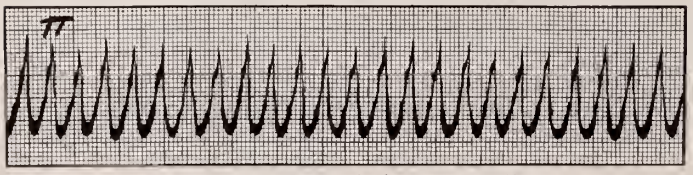
restore normal sinus rhythm



1. Premature ventricular contractions

2. Paroxysmal auricular tachycardia



3. Paroxysmal ventricular tachycardia

in arrhythmias

VISTARIL* hydroxyzine pamoate

More than a tranquilizer

SPECIFIC ANTIARRHYTHMIC EFFECT

Vistaril is effective in ventricular extrasystoles and paroxysmal tachycardias (both auricular and ventricular).

plus

PSYCHOTHERAPEUTIC POTENCY

proven calming action indicated for arrhythmia patients.

and

THE OUTSTANDING SAFETY

of Vistaril as compared to other antiarrhythmic drugs in general use has been noted by investigators.

THE FOLLOWING DOSAGE REGIMEN IS RECOMMENDED (individualized by the physician for maximum effectiveness):

PARENTERAL DOSAGE: 50-100 mg. (2-4 cc.) I.M. stat., and q. 4-6 h., p.r.n.; maintain with 25 mg. b.i.d. or t.i.d. In acute emergency, 50-75 mg. (2-3 cc.) I.V. stat.; maintain with 25-50 mg. (1-2 cc.) I.V. q. 4-6 h., p.r.n.

ORAL DOSAGE: Initially, 100 mg. daily in divided doses until arrhythmia disappears. For maintenance or prophylaxis, 50-75 mg. daily in divided doses.

SUPPLY: Vistaril Capsules, 25 mg., 50 mg. and 100 mg. Vistaril Parenteral Solution, 10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. (as the hydrochloride).

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References: 1. Burrell, Z. I., et al.: Am. J. Cardiol., 1:624 (May) 1958. 2. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:451 (Dec.) 1956.

*Trademark

News from the Specialty Societies

Milwaukee Academy of Medicine

Dr. Russell Meyers, professor of surgery and chairman of the Division of Neurosurgery at the State University of Iowa, addressed the members of the Milwaukee Academy of Medicine at their meeting March 17th at the University Club of Milwaukee. Doctor Meyers discussed "Inquiry into the Neural Mechanisms of Abnormal Movement and Intractable Pain by Ultrasound."

Milwaukee Neuro-Psychiatric Society

On March 18th the Milwaukee Neuro-Psychiatric Society met at the University Club of Milwaukee. During the dinner program Dr. Walter H. Obenauf, who is speaker for the Assembly of District Branches of the American Psychiatric Association, talked on "The District Branch of the A.P.A.—Its Origin, Present Status, and Future Development."

Dr. John I. Nurnberger, professor and chairman of the Indiana University Medical Center, was guest speaker at the April 15 meeting of the Milwaukee Neuro-Psychiatric Society held at the University Club. His topic was, "Pseudodepression: A Pharmacological Fallacy."

Physicians whose names appear in italic are members of the Society.

Milwaukee Oto-Ophthalmic Society

Members of the Milwaukee Oto-Ophthalmic Society heard Dr. Jack S. Guyton, Chief Department of Ophthalmology, Henry Ford Hospital, Detroit, Michigan, speak on the subject, "Ocular Surgery," at the April 28 meeting held at the University Club.

Wisconsin Psychiatric Association

Dr. L. J. Ganser was installed as president of the Wisconsin Psychiatric Association at a meeting held April 3 at the Cuba Club, Madison. Doctor Ganser is superintendent of the Wisconsin Diagnostic Center. He succeeds *Dr. Max Smith*, Madison, to the post.

Other officers elected were: *Drs. Gilbert Tybring*, Madison, president-elect; *Harold M. Lubing*, Madison, secretary; *Keith Keane*, Appleton, treasurer; and *Charles Landis*, Milwaukee, and *Carl L. Kline*, Wausau, council members.

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A 65-bed institution for the treatment of nervous and mental illnesses.

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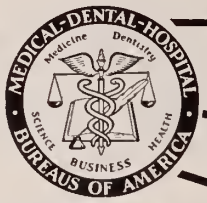

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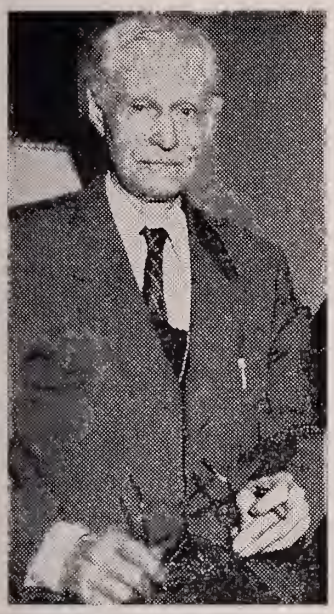
John F. Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.
Preston W. Thomas, M. D.

THIRD AND TWELFTH DISTRICTS

Doctor Crockett Transfers Offices

A veteran Beloit physician, *Dr. W. W. Crockett*, recently closed his downtown office and set up an office in his home. The 89-year-old physician and surgeon has practiced in Beloit for 55 years. He started his medical career in 1896 at Roscoe, Illinois, after completing his medical education at Northwestern University. He came to Beloit seven years later.



Doctor Crockett
Photo courtesy
Wisconsin State Journal

The spry and witty Doctor Crockett does not intend on retiring. During his many years of practice, Doctor Crockett has been chief of staff of the H. B. Strong Emergency Hospital, physician for many of Beloit's industries, and for 50 years has acted as head surgeon for the Milwaukee Road in Beloit. He has also been a city health commissioner; he was the first president of the medical staff of Beloit hospital when it opened its doors 30 years ago. He has been feted by the State Medical Society in recognition of his 50 years of service to the profession by being named to the "Fifty Year Club", and Northwestern University has recognized him for his outstanding service.

Physicians whose names appear in italic are members of the Society.

Doctor Engstrom New Director

Dr. W. W. Engstrom has accepted the position of director of medicine at the Milwaukee County General Hospital. The post is one he has held on a part time emergency basis since July, 1958. The clinic director's position was set up on a full-time basis to handle responsibilities formerly assigned to *Dr. Harold E. Cook*, who is now director of all medical services at the county institutions. Doctor Engstrom is chairman of the department of medicine at Marquette University School of Medicine.

Dr. Engstrom

Doctor Weinshel CD Medical Director

Dr. Leo Weinshel has been appointed medical director of the Medical–Hospital Services Division of the Milwaukee County Civil Defense organization. He succeeds *Dr. Harold E. Cook* in this post and as chairman of the Medical–Hospital Advisory Committee.

As director of this Civil Defense division, Doctor Weinshel will direct the activity of approximately 11,000 medical and ancillary personnel.

Doctor Crepea Speaks

Dr. Seymour B. Crepea lectured on the topic, "Gamma Globulin in Infectious Asthma of Children," before the Committee on Therapy at the American Academy of Allergy meetings held in Chicago from February 7–13. Doctor Crepea, Madison, is Associate Professor of Medicine at the University of Wisconsin.

(continued)

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Founded 1903. Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Varied group activities under competent direction on our spacious grounds of 28 acres. Selected movies.

Separate buildings for boys and girls, each with round-the-clock supervision of skilled personnel. Total enrollment 90.

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when pollen allergens attack the nose...

Triaminic provides more effective therapy in respiratory allergies because it combines two antihistamines[1,2] with a decongestant.

These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

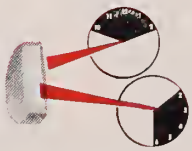
The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.[4,5]

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.[6,7] TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: Postgrad. Med. **14**:165 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy **19**:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly **37**:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. **112**:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958.

Triaminic®

TRIAMINIC provides around-the-clock freedom from hay fever and other allergic respiratory symptoms with just one tablet q. 6-8 h. because of the special timed-release design.



Each TRIAMINIC timed-release tablet provides:
Phenylpropanolamine HCl.....50 mg.
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Also available: TRIAMINIC SYRUP for those patients of all ages who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet. TRIAMINIC JUVELETS provide half the dosage of the Triaminic Tablet with the same timed-release action for prompt and prolonged relief.

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NONSTOP RELIEF FROM NEW YORK TO ISTANBUL

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You can prescribe these Schering products in REPETAB *form*

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DEMAZIN® REPETABS, 4 mg.
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symbol of the one-dose convenience you want for your patient

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(antibacterial detergent, nonalkaline, nonirritating, hypoallergenic)

tips the balance for superior results

Winthrop LABORATORIES
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1. Hodges, F. T.: GP 14:86, Nov., 1956.

The award, given by the Lederle Laboratories, is designed to provide support for continued development of a promising teacher and investigator in fields of medicine and human biology. Doctor Morton will be supported under the grant for three years.

Doctor Morton came to Wisconsin in 1951 as a graduate student in genetics. In 1952–53 he served as geneticist for the Atomic Bomb Casualty Commission in Japan, where he investigated effects of radiation exposure in Hiroshima and Nagasaki.

In 1953 Doctor Morton returned to Wisconsin, and obtained the Ph.D. in genetics in 1955. That same year he was named a postdoctoral fellow of the National Cancer Institute, and in 1956 he was appointed the first faculty member of the new department of Medical Genetics.

Research pursued by Doctor Morton at Wisconsin includes methods for detection of genetic linkage in man, and for estimating the rate of human mutation. He has also done original work in the genetics of deafness and muscular dystrophy.

In addition to publishing a long list of research papers himself, Doctor Morton serves as an associate editor of the American Journal of Human Genetics.

At Wisconsin, during the next three years, Doctor Morton will continue to do advanced research and teaching in human genetics.

Psychiatry Training Program Approved

Joint approval from the American Medical Association and the American Psychiatric Association of a training program in psychiatry that would involve the rotation of psychiatrists through four major institutions in Milwaukee has been received. The announcement was made by heads of the four institutions: Waldo W. Buss, executive director of Milwaukee Sanitarium Foundation; D. C. Firmin, manager of the Veterans Administration Hospital, Wood; Dr. John S. Hirschboeck, dean of the medical school; and John W. Rankin, director of the Milwaukee County Institutions and Departments.

The program, which is regarded by its sponsors as a major step in the development of psychiatric services in this area, was proposed by the four institutions in November, 1958. It will provide opportunities to train a maximum number of psychiatrists in the Milwaukee area. The program will begin in July, 1959, and it is expected to enroll 27 residents.

Thailand Physician Studies with Doctor Fox

Dr. Bhuket Vachananda of Bangkok, Thailand, who received his Ph.D. from the University of Michigan in June, 1958, spent the months of February and March with Dr. Clement A. Fox, professor and associate chairman of the Department of Anatomy at Marquette, studying with the use of Doctor Fox's Golgi preparations. He has been studying the cerebellar cortex. Doctor Vachananda is in this country under a Thailand government scholarship.

Medical Meetings - Postgraduate Courses

Conference on Mental Retardation

The first international medical conference on mental retardation will be held July 27–31 at the Eastland Hotel in Portland, Maine. Guest speakers are from many foreign countries as well as the United States.

For further information write: Conference Secretary, International Medical Conference on Mental Retardation, % Division of Maternal and Child Health State House, Augusta, Maine.

Postgraduate Course in New York

The Woman's Hospital Division of St. Luke's Hospital in New York City offers a one-week course in, "The Conduct of Labor and Delivery". This is for general practitioners and thirty hours Category I Credit is allowed by the American Academy of General Practice. The time of the course is October 8 through October 14, 1959. Enrollment will close on September 15, 1959.

The course consists of lectures, demonstrations, work in the prenatal and postpartum clinics and assistance in the delivery room. Enrollment is limited. If interested, please write to: Mr. Carl P. Wright, Jr., Director, Woman's Hospital, 141 West 109th Street, New York City for prospectus and details.

North Shore Hospital Lecture

The closing lecture in the Ninth Annual North Shore Hospital Lecture Series on, "Emotional Forces In the Family," will be held at the hospital, 225 Sheridan Road in Winnetka, Illinois, on Wednesday, June 3, at 8:00 P. M. "The Family of the Future" will be discussed by Lawrence S. Kubie, M. D., Clinical Professor of Psychiatry, Yale University School of Medicine; Lecturer in Psychiatry, College of Physicians and Surgeons of Columbia University; Faculty, New York Psychoanalytic Institute.

University of Minnesota Courses

Medical continuation courses to be presented at the Center for Continuation Study, University of Minnesota, are as follows:

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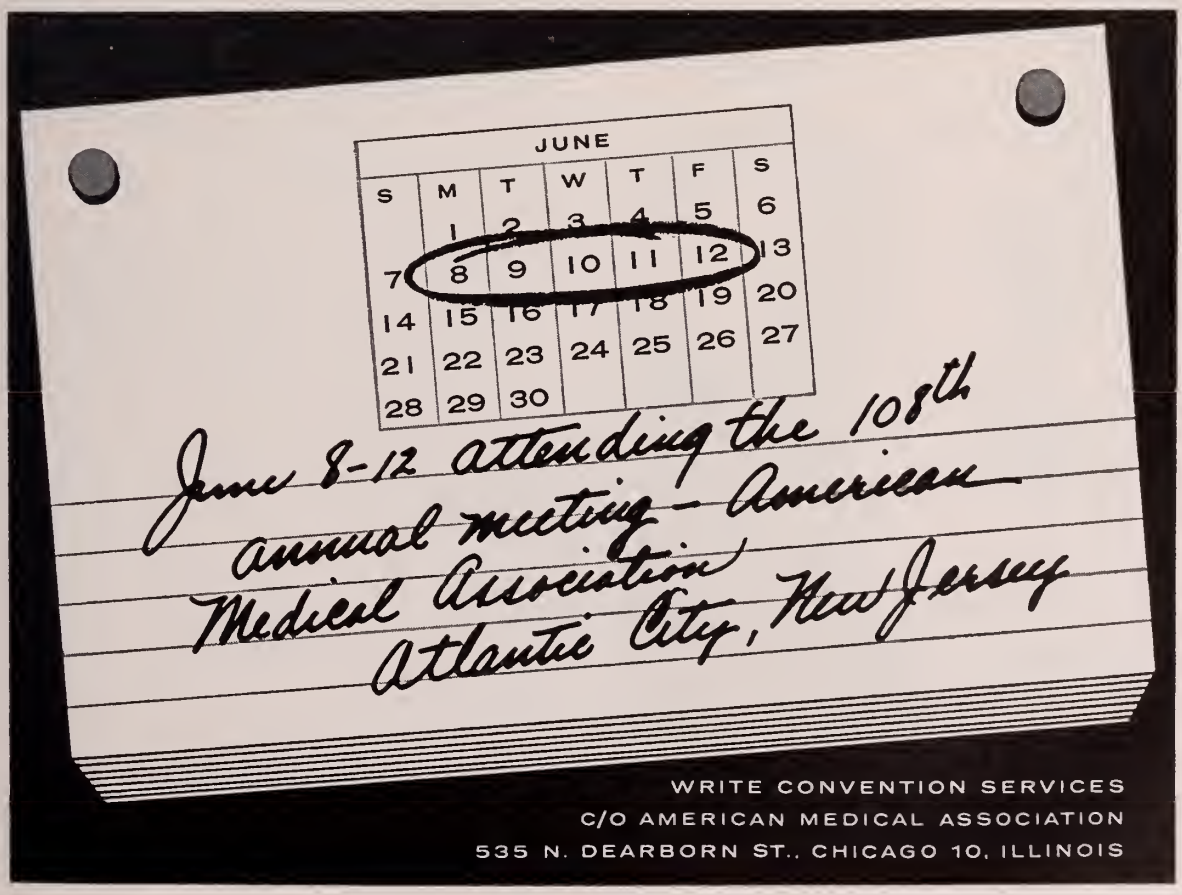

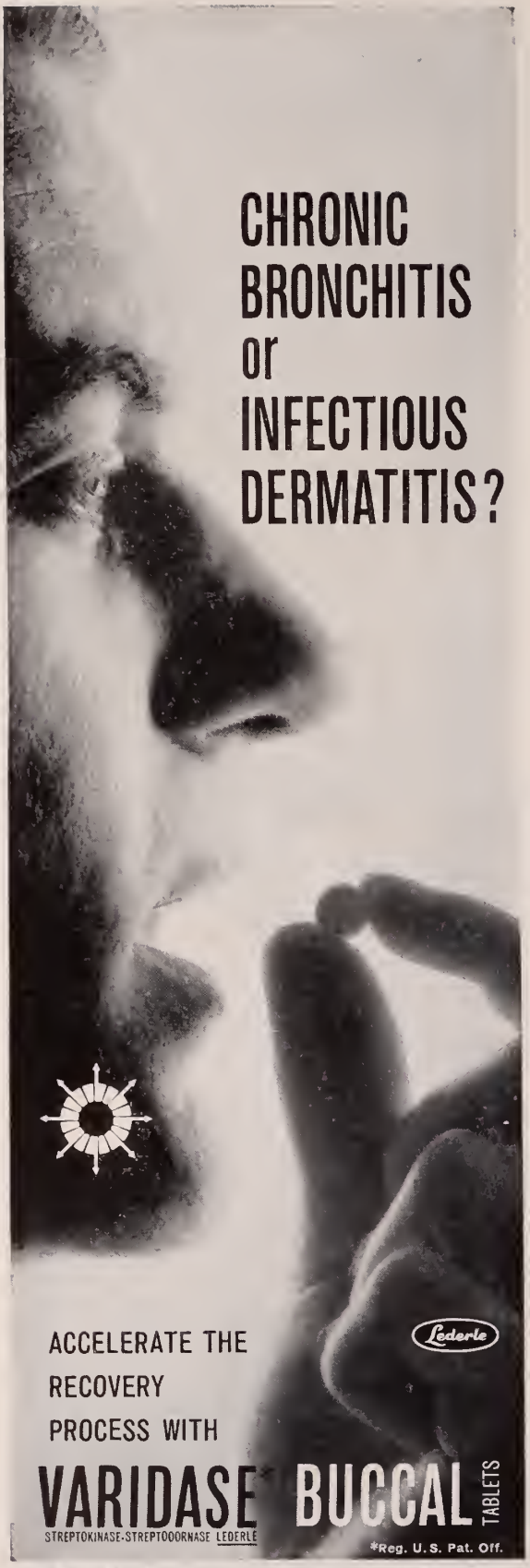

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MEDICAL MEETINGS (continued)

May 27–29: Otolaryngology for specialists.
June 15–17: Gynecology for general physicians.

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minn.

World Postgraduate Tour

The International College of Surgeons announced that it will hold its fourth around-the-world postgraduate refresher clinic tour in the late Fall.

Departure will be by plane from San Francisco, October 10. Tour participants will take in specially arranged meetings of I.C.S. Sections in Tokyo, October 18–19; Hong Kong, October 29–30; Bangkok, November 2; Tel Aviv, November 20; Istanbul, November 24, and Athens, November 27.

Sightseeing trips have been arranged for these and other countries, including Thailand, India, Ceylon, Egypt, Lebanon, and Jordan. Arrival in New York will be about December 1. Accommodations are limited.

For further information, write to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, or to the International Travel Service, Inc., 119 South State Street, Chicago 3, Ill.

A.M.A. Annual Meeting

Some 15,000 physicians will gather in Atlantic City June 8–12 for the 108th annual meeting of the American Medical Association.

Among the many medical topics to be covered are hypnosis, staphylococcal infections, blood cell disorders, space medicine, viruses and aging.

A special feature of the meeting will be a symposium on aging on Wednesday, June 10. Speakers will include Dr. Frederick Swartz, Lansing, Mich., chairman of the A.M.A. Committee on Aging, and Dr. David B. Allman, Atlantic City, and Dr. Edward L. Bortz, Philadelphia, both past presidents of the A.M.A.

More than 400 physicians will present scientific papers or participate in panel discussions and symposiums. In addition, there will be 387 scientific exhibits shown by physicians and 285 industrial exhibits prepared by pharmaceutical houses, medical equipment manufacturers, and other commercial organizations.

Most of the scientific sessions, along with the exhibits, will be held in the Atlantic City Convention Hall. The House of Delegates, the A.M.A. policy-making body, will meet throughout the week in the Traymore Hotel, headquarters for the meeting.

Dr. Louis M. Orr, Orlando, Fla., will be inaugurated as president of the A.M.A. Tuesday evening. He will succeed Dr. Gunnar Gundersen, La Crosse, Wis. The inaugural will be followed by a reception and ball, at which Lester Lanin and orchestra will play.

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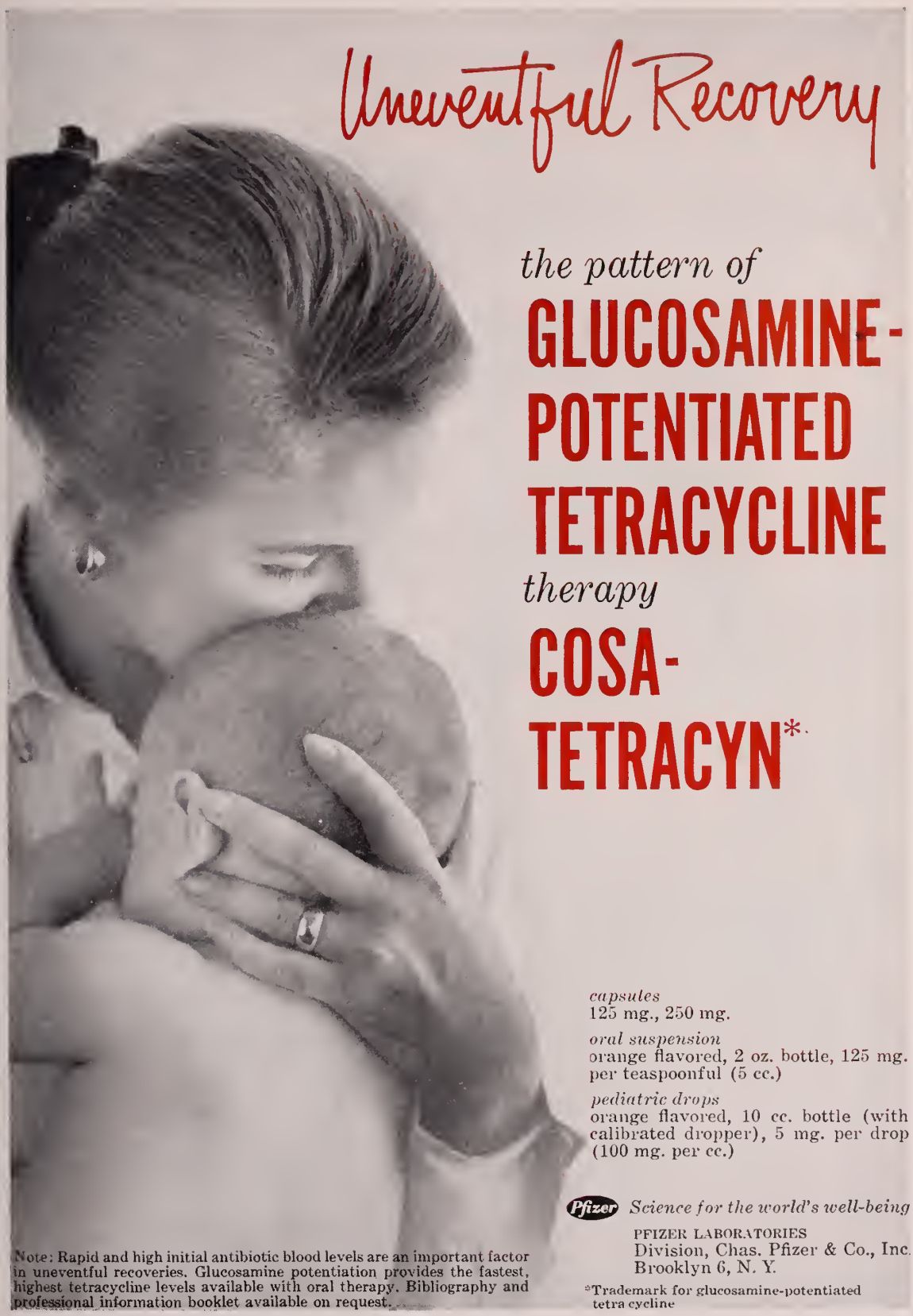
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MEDICAL MEETINGS (continued)

Other features of the meeting include:

The seventh annual National Civil Defense Conference, sponsored by the A.M.A. Council on National Defense, on Saturday, June 6. The program will be presented entirely by the Army Medical Service.

Meetings by the Woman's Auxiliary to the A.M.A. at Hotel Haddon Hall. Mrs. Frank Gastineau, Indianapolis, will be installed at president, succeeding Mrs. E. Arthur Underwood, Vancouver, Wash.

Art exhibits by the American Physicians Art Association in Convention Hall.

Special exhibits in the scientific section by high school students who won A.M.A. awards in the National Science Fair.

Other Dates to Remember

Aug. 31–Sept. 4, 1959—Second World Conference on Medical Education, Chicago, Ill.

Sept. 7–12, 1959—13th General Assembly, The World Medical Association, Montreal, Canada.

Oct. 13–15, 1959—7th National Conference on Physicians and Schools. Conference theme: Significant Issues in School Health and Physical Education. Moraine-on-the-Lake Hotel, Highland Park, Illinois.

Oct. 19–23, 1959—87th annual meeting of the American Public Health Association. Atlantic City Convention Hall.

Nov. 29–Dec. 2, 1959—1959 annual convention of the National Society for Crippled Children and Adults. Palmer House, Chicago. Further information contact: Miss Catharine Bauer, Director of Information, 2023 West Ogden Avenue, Chicago 12, Ill.

Nov. 30–Dec. 9, 1959—American Academy for Cerebral Palsy, 1959 annual meeting, Los Angeles, Calif., Hotel Statler. Further details: Glidden L. Brooks, M.D., Secretary, Brown University, Providence 12, R. I.

May 2–11, 1960—Pan American Medical Association Congress. Mexico City. For information write Dr. Joseph J. Eller, Director General, 745 Fifth Avenue, New York, N. Y.

(continued)

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Wisconsin State Medical Assistants

The fifth annual meeting of the Wisconsin State Medical Assistants is being held at the Eau Claire Hotel, Eau Claire, Wisconsin, June 5–7, according to the president, Miss Violet Owen, Stoughton.

Saturday morning speakers will be Lt. L. A. Pavlinski, Wisconsin State Patrol, who will talk on, "Alcohol Detection in the Human Body," and Jack Burke, assistant to the editor and publisher of the *Capital Times*, Madison. His topic will be, "The Heartbeat of a Newspaper." Saturday afternoon Dr. Harold Mickelson, Professor of Business Education, State Teachers College, Kirksville, Missouri, will discuss, "Division of Duties in the Doctor's Office," and Paul Boley, Eau Claire County Civil Defense Co-ordinator, will speak on, "Your Place in Civil Defense."

Dr. D. E. Dorchester of Sturgeon Bay will be the master of ceremonies at the banquet Saturday evening when Dr. Sarah Rosekranz, Neillsville, will be the guest speaker.

The business meeting will be held Sunday morning, and the convention will end with the luncheon Sunday noon. The convention chairman is Miss Ima Lee, Chippewa Falls.

Brazilian Medical Congress

The Brazilian Medical Association has postponed its II Congress, originally scheduled for the first week of September, to convene September 26–October 4. The theme of the Conference is "Improving Medical Care Standards."

The dates of the meeting were changed in order that delegations to the Second World Conference on Medical Education (Chicago, August 30–September 4) and the XIIIth General Assembly of The World Medical Association (Montreal, Canada, September 7 to 12) would be able to attend the Brazilian Conference in Sao Paulo.

International College of Surgeons

The United States Section, International College of Surgeons, has formed the Section on Surgery of Trauma as a successor to the Section on Occupational Surgery.

Dr. Chester C. Guy, clinical associate professor of surgery at the University of Illinois College of Medicine, Chicago, is chairman of the section and Dr. N. Gillmor Long, Evanston and Chicago, is co-chairman and secretary.

(continued)

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MEDICAL MEETINGS (continued)

The Section on Surgery of Trauma will provide a forum for those surgeons whose work is limited to traumatic lesions and for those who treat lesions frequently in their daily practice. The section will deal with developments in the treatment of specific injuries, consider programs for the prevention of injuries, conduct studies on basic physiologic and pathologic changes in the injured person, and give thought to allied subjects.

* * *

The 24th annual Congress of the North American Federation, International College of Surgeons, will be held in Chicago, September 13–17. The federation is composed of the United States, Canadian, Mexican, and Central American Sections. For information, write to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10.

* * *

The 12th biennial International Congress of the International College of Surgeons will be held in Rome, Italy, May 15–18, 1960. For information write to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10.

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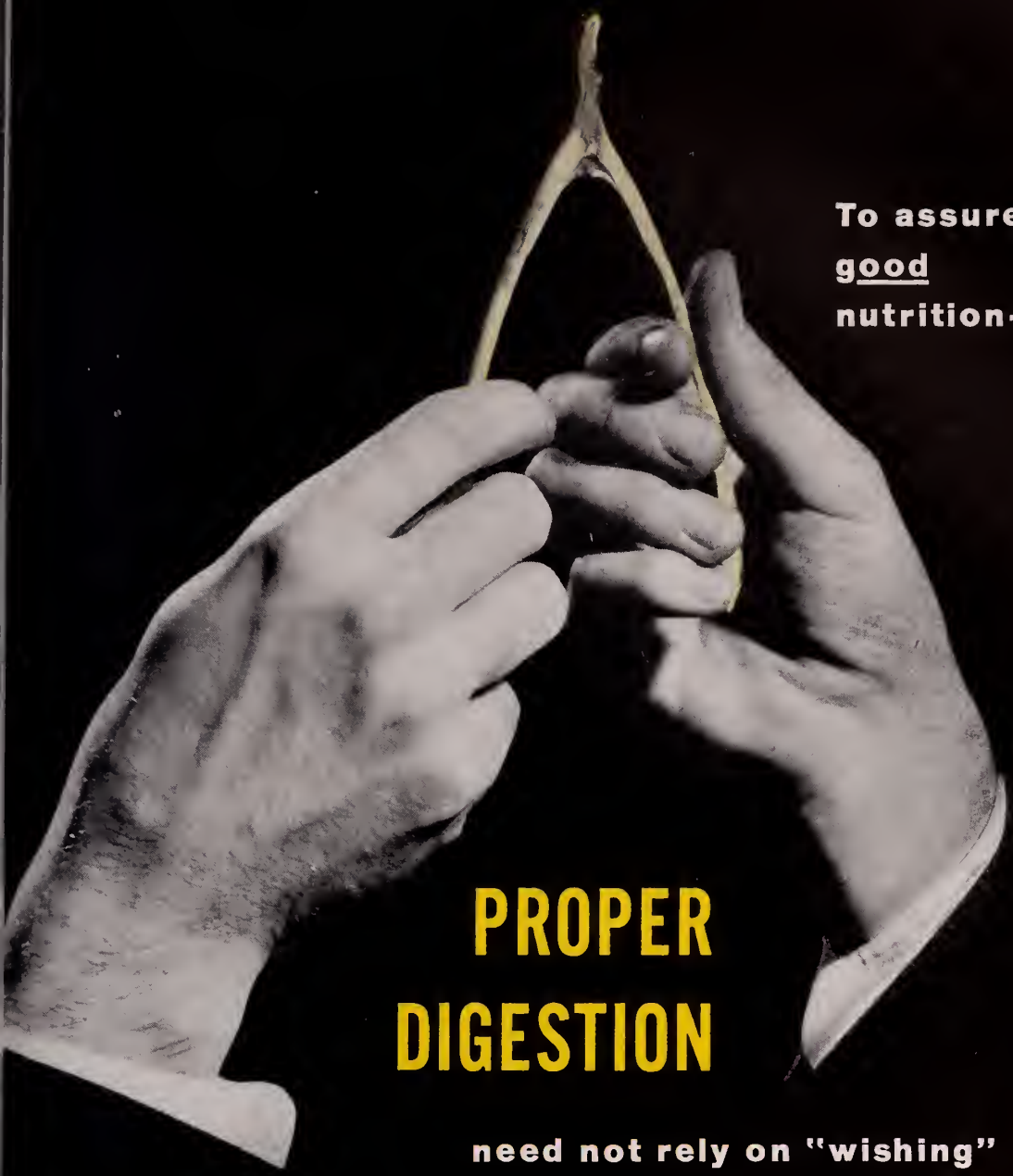

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American Heart Association

The 1959 annual meeting and scientific sessions of the American Heart Association will be held October 23–27 in Philadelphia. The scientific sessions are scheduled for October 23–25 at the Trade and Convention Center. The annual meeting of the National Assembly, delegate body representing all program interests and geographical areas of the Association, will be held in the Hotel Bellevue Stratford, October 26–27.

A deadline of June 12 has been set for submission of abstracts of papers to be presented at the scientific sessions and for space applications for scientific exhibits. Papers intended for presentation must be based on original investigation in, or related to, the cardiovascular field. Official forms for submitting abstracts and space applications for scientific exhibits may be obtained from Dr. F. J. Lewy, Assistant Medical Director, American Heart Association. Applications for space for industrial exhibits may be requested through Steven K. Herlitz, Inc., 280 Madison Avenue, New York 16, N. Y.

Inquiries concerning hotel reservations and the Assembly meetings may be addressed to William F. McGlone, Secretary, American Heart Association, 44 East 23rd Street, New York 10, N. Y.

International Goiter Conference

The Fourth International Goiter Conference will be held July 5–9, 1960, in London, England, under the auspices of the London Thyroid Club and the American Goiter Association. The American Goiter Association plans to make available to worthy candidates a limited number of travel grants for participants of this meeting.

Application blanks are available from John C. McClintock, M.D., 149½ Washington Avenue, Albany 10, New York.

Applications will be received until January 1, 1960.

Illinois Postgraduate Courses

The Department of Otolaryngology, University of Illinois College of Medicine, announces two special postgraduate courses to be offered in the fall of 1959:

Annual Otolaryngologic Assembly

The Assembly will be conducted September 18 through September 26, 1959, and will consist of a series of lectures and panels concerning advancements in otolaryngology. Some of the sessions will be devoted to surgical anatomy of the head and neck and histopathology of the ear, nose and throat. Guest lecturers will participate in an entire day's program reviewing the latest advances and principles of temporal bone surgery. Chairmen of the Assembly are Maurice F. Snitman, M.D., and Emanuel M. Skolnik, M.D.

Course in Laryngology and Bronchoesophagology

The course in laryngology and bronchoesophagology, under the chairmanship of Paul H. Holinger, M.D., is scheduled November 9 through November 21, 1959. Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

Pan-Pacific Surgical Association

The Eighth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, September 28 through October 5 in 1960.

All members of the profession are cordially invited to attend and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program by leading surgeons promises to be of interest to all physicians. Nine surgical specialty sections are held simultaneously.

Further information and brochures may be obtained by writing to: Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

A. M. A. MEETING TO FEATURE SPECIAL SESSION ON AGING

A special session on new concepts in aging will be held during the annual convention of the American Medical Association in Atlantic City, June 8–12.

This one-day session, to which all physicians are invited, will be held in Room C of the convention hall at 9 A.M. Wednesday, June 10, under auspices of the A.M.A. Committee on Aging.

The meeting is designed to present the practicing physician with a concentrated review of current thinking regarding health care of the aged, and to provide him with concrete health recommendations which he can translate to his own older patients.

Keynoting the session will be a series of panels devoted to Diseases Among the Aged, Nutritional Counseling, Promoting Physical Fitness, and Motivating the Older Person. Panelists will cover such points as (1) special treatment aspects of cardiovascular, neoplastic and bone diseases among the aged, (2) effects of adequate nutrition on rehabilitation potential for older patients, (3) variables in prescribing a physical activity program for the older individual and (4) the effects of physical health, social adjustment and psychological functioning on motivation in the older person.

Obituaries

Dr. Pauline Leader, a pioneer Iowa physician, died February 7 in Lancaster where she had been living for the past five years. She had celebrated her 101 birthday in January.

Doctor Leader graduated from medical school at the University of Iowa in 1894 when she was 36 years of age. She had taught school prior to her medical training. Doctor Leader practiced 42 years in Iowa, first at Davenport and then at the Clarinda Hospital for the mentally ill. While in Davenport she organized the training school for nurses which she headed.

Surviving is her sister of Lancaster.

Dr. Charles F. Allen, of Middleton, died February 17 at the age of 85 after a short illness. He had been retired since 1957.

Doctor Allen was born in Milwaukee in 1873. He graduated from the Milwaukee Medical College in 1900 and immediately began practicing in Middleton where he remained until retirement. As one of the oldest doctors in Middleton, he was honored at a special Doctors' Day celebration in 1949, commemorating his 50 years of service to the community.

Doctor Allen formerly held memberships in the Dane County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his widow, Dorothy. Two physician brothers, Dr. Lester Allen of Albany and Dr. Sylvester Allen of Waterloo, preceded him in death in 1958.

Dr. A. M. Dorr, a Milwaukee roentgenologist for 40 years, died February 24. He was 72 years of age.

Born in 1886 at Milwaukee, he spent his early years as a reporter for two Milwaukee newspapers. Doctor Dorr attended Northwestern University, receiving his medical degree in 1912. Following an internship at Milwaukee County General Hospital, he worked for a short time as a physician at a lumber camp at Laona and settled in Milwaukee in 1914. He retired 10 years ago.

Doctor Dorr was a past member of the State Medical Society of Wisconsin, The Medical Society of Milwaukee County, and the American Medical Association. He was past president of the Milwaukee Roentgenological Society and held membership in the Milwaukee Academy of Medicine.

His widow, a son and two daughters survive.

Dr. R. N. Leasum, Osseo, succumbed February 27 at the age of 67.

Doctor Leasum was born at Kendall in 1892. He was a 1918 graduate of the Jefferson Medical School, Philadelphia, Pennsylvania, and interned at St. Joseph's Hospital in Philadelphia. He spent his entire years in the medical profession practicing in Osseo. Doctor Leasum was a veteran of World War I and was an examiner for several life insurance companies.

He was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of Medical Practice.

Survivors include his widow, Gertrude; two sons, Dr. Robert, Jr., who was associated with him in practice, and Jay, La Crosse; and two daughters, Mrs. Gertrude Weaver, Wooster, Ohio, and Mrs. Mary Markovich, Waukesha.

Dr. R. G. Gallimore, a Milwaukee physician, died March 2 at the age of 42.

Born in Monroe in 1917, Doctor Gallimore graduated from Creighton University in 1943. He interned at Grace Hospital, Detroit, Michigan, the following year and then served with the U. S. Army Medical Corps. Upon release from the military he returned to Grace Hospital to serve a three-year residency in obstetrics and gynecology. Doctor Gallimore established his Milwaukee practice in 1950.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the Wisconsin Obstetrical–Gynecological Society.

Doctor Gallimore is survived by his widow, Harriet, a physician at the Milwaukee vocational school, and three children.

Dr. G. J. Juckem, a Sheboygan physician and surgeon, died unexpectedly March 8. He was 67 years of age.

Doctor Juckem was born in 1892 at Sheboygan. He received his medical degree from Marquette University in 1915. During the next year he served an internship at Swedish Hospital, Minneapolis, Minnesota, and began his first practice at Big Sandy, Montana. From 1917 to 1918 he served as a captain in the U. S. Army Medical Corps, and was stationed in San Antonio, Texas, at the base hospital. He returned to Montana to practice at Red Lodge and in 1921 moved to Howards Grove. He left there in 1925 for a year of graduate training at the University of Vienna. His Sheboygan practice was established in 1926.

Memberships held by Doctor Juckem included those with the Sheboygan County Medical Society of Wisconsin, the American Medical Association, and the Association of Military Surgeons.

His widow, Meta, a son, and a daughter survive.

Dr. Mary Bartlett, 89, died March 11 at her Beloit home. She had practiced in that city for nearly 60 years.

A native of Beloit, Doctor Bartlett was born in 1869. As one of four physician daughters in a nine-

(continued)

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OBITUARIES (continued)

child family, she graduated from medical school at Hanneman College in 1899. She entered retirement a year ago.

A sister, Dr. Etta Vaughn of Beloit, survives.

Dr. Edith McCann, 72, died March 19 following a lingering illness. The Milwaukee obstetrician, gynecologist and pediatrician retired in 1955.

She was born at Aberdeen, South Dakota, in 1886, graduated from the University of Illinois in 1914 and opened an office in Milwaukee in 1917.

During her career, Doctor McCann was medical inspector of Milwaukee public schools, was medical consultant for nine years at the Wisconsin School for Girls and had been on the staffs of Milwaukee and Columbia Hospitals. She founded the Planned Parenthood Clinic and the Goodwill Industries in Milwaukee and was active in prenatal clinics.

Medical society affiliations included those with The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin Society of Obstetricians and Gynecologists, and the Milwaukee Academy of Medicine.

Surviving is a sister, Mrs. Gertrude M. Briggs of Long Beach, California.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

The Clinical Examination of The Nervous System. By G. H. Monrad-Krohn, M.D., F.R.C.P. With assistance of Sigvald Refsum, M.D., Professor of Neurology, University of Oslo, Norway. Eleventh edition. Pp. 466, 173 illustrations. Paul B. Hoeber, Inc., New York.

The 11th publishing of "The Clinical Examination of the Nervous System" by G. H. Monrad-Krohn is a much revised edition. The famous author, Monrad-Krohn is fortunate indeed to have in Sigvald Refsum not only a highly qualified collaborator, but also Refsum as his successor in the clinical teaching from Monrad-Krohn's former professional chair of Neurology at the University of Oslo.

The valuable content of this book has attested itself by the many editions and by the popular response among students and physicians. The material for the physical examination is well outlined. Page 78 should have a better picture instead of a queer, perhaps oriental drawing. A picture of a true facial spasm would be much more appropriate. I question why a text book specifically for the clinical examination in neurology should have thirteen pages describing the mental state and why some nine pages 273 to 281 have to be dedicated "to measuring of intelligence." The antiquated sketches Figures 87–86 should be eliminated. The Chapter on "Examination of Cerebrospinal Fluid"—is in my opinion too long. One may question some of the statements such as "pressure relations", and within the description of counteracting on Page 486 "hyperosmotic administration" one should use or add urea as the present day drug to reduce increased intracranial pressure.

In my opinion there are too many pictures of angiography which are only confusing to the student and the physician. The diagram on page 341 could be improved, and Figure 108 should be replaced by a more instructive and clearer base of the skull. Page 270 states in Figure 85 "the lipiodol shadow". I do not believe that lipiodol is used presently in any of the clinics, since there are superior contrasts media which can be removed with ease. These critical remarks are perhaps of minor importance in an evaluation of the very successful guide for our medical students. The clear descriptions are so helpful to a beginner and student in neurology. I recommend Monrad-Krohn's The Clinical Examination of the Nervous System to all students and physicians for a quick and thorough evaluation not only of their clinical examination but for getting the many hints of how to observe and how to examine a patient. The points of criticism may be acknowledged by the author and his collaborator. I am of the opinion that this book will maintain its place on the desk or shelf of the next generation of students and physicians.
—*Hans H. Reese, M.D.*

Cerebrovascular Diseases Conference Transactions Are Published

The transactions of the Second Conference on Cerebrovascular Diseases, held under sponsorship of the American Heart Association in Princeton, N. J., January 16–18, 1957, have been published by Grune and Stratton, Inc., 381 Fourth Avenue, New York 16, N. Y., at $4.00 a copy.

Entitled "Cerebral Vascular Disease," the transactions include a classification and outline of cerebrovascular disease as reported by an ad hoc committee established by the Advisory Council for the National Institute of Neurological Diseases and Blindness of the U. S. Public Health Service.

Dr. Irving S. Wright, New York, was Chairman of the Conference. He and Dr. Clark H. Millikan, Rochester, Minn., served as editors for the volume.

Proceedings of AHA Scientific Sessions Available to Physicians and Scientists

The Proceedings of the American Heart Association's 31st Annual Scientific Sessions, held in San Francisco, October 24–26, 1958, which include 342 abstracts of current investigative work, may still be obtained by interested physicians and scientists.

Also included in the Proceedings are summaries of the Lewis A. Conner and George E. Brown Memorial Lectures, delivered respectively by Dr. John H. Gibbon, Jr., Professor of Surgery, Jefferson Medical College, Philadelphia, and Dr. Lewis Thomas, Professor and Chairman, Department of Medicine, New York University College of Medicine. To serve as a useful reference to physicians, abstracts are arranged in alphabetical order according to senior author.

The 143-page, paper bound volume may be obtained at $2.00 a copy from the American Heart Association, 44 East 23rd Street, New York 10, N. Y.

New Volume Issued on Pulmonary Circulation

An extensive review of the subject of pulmonary circulation, based on the transactions of the International Symposium on Pulmonary Circulation sponsored by the Chicago Heart Association, March 20, 1958, is now available in book form.

(continued)

The newly-published volume, edited by Drs. Wright R. Adams and Ilza Veith, reports results and clinical application of recent research in the field of pulmonary circulation, and also includes stimulating discussions on the topic by leading specialists. Entitled "Pulmonary Circulation", the 368-page volume includes 127 illustrations. It is obtainable at $4.50 a copy from the publisher, Grune and Stratton, Inc., 381 Fourth Avenue, New York 16, N. Y.

BOOKS RECEIVED

Unsaturated Fats and Serum Cholesterol. By Dorothy M. Rathmann, Ph.D., Technical Division, Corn Products Refining Company, Argo, Illinois. Corn Products Refining Co., 1958. 47 pages.

Water and Electrolyte Metabolism in Relation to Age and Sex, Vol. 4, Ciba Foundation Colloquia on Ageing. By G. F. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc., editors for the Ciba Foundation. Little Brown & Company, Boston, Massachusetts. 1958. 85 illustrations. 327 pages. Price: $8.50.

Epilepsy. By Manfred Sakel, M.D. Philosophical Library, Inc., 15 East 40th Street, New York. 1958. 204 pages. Price: $5.00.

Schizophrenia. By Manfred Sakel, M.D. Philosophical Library, Inc., 15 East 40th Street, New York 16, N. Y. 1958. 335 pages. Price: $5.00.

Neurological Basis of Behavior. Ciba Foundation Symposium. By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc., editors for the Ciba Foundation. Little Brown & Company, Boston, Mass. 1958. 109 illustrations. 400 pages. Price: $9.00.

What We Do Know About Heart Attacks. By John W. Grofman, M.D., Professor of Medical Physics, University of California, Berkeley. G. P. Putnam's Sons, New York. 1958. 180 pages. Price: $3.50.

Clinical Obstetrics and Gynecology. A Quarterly Book Series. Symposium on Genital Cancer, edited by Daniel G. Morton, M.D. Symposium on Operative Obstetrics, edited by J. Robert Willson, M.D. Paul B. Hoeber, Inc., 49 East 33 St., New York 16, N. Y. December 1958. 1138 pages. Subscription price: $18.00/year.

A Method of Anatomy; Descriptive and Deductive. By J. C. Boileau Grant, M.C., M.B., Ch.B., F.R.C.S. (Edin.), Professor Emeritus of Anatomy in the University of Toronto and Curator of the Anatomy Museum. Sixth Edition. The Williams & Wilkins Company, Baltimore. 1958. 879 pages. Price: $11.00.

Cold Injury, Ground Type. Prepared under the direction of Major General S. B. Hays, The Surgeon General, United States Army. By Colonel Tom F. Whayne, MC, USA (Ret.), Professor of Preventive Medicine, School of Medicine, University of Pennsylvania, Philadelphia, Pa., and Michael E. DeBakey, M.D., Professor of Surgery and Chairman of the Department, Baylor University College of Medicine, Houston, Texas, formerly Colonel, MC, AUS. Medical Department, United States Army, Office of the Surgeon General, Washington, D. C. 1958. 570 pages. Price: $6.25.

Embryonic Nutrition. Edited by Dorothea Rudnick, Professor of Biology at Albertus Magnus College, New Haven, Connecticut. The University of Chicago Press, 5750 Ellis Avenue, Chicago 37, Illinois. 1958. 113 pages. Price: $3.25.

Anatomy for Surgeons, Volume III: The Back and Limbs. By W. Henry Hollinshead, Ph.D., Professor of Anatomy, Mayo Foundation, University of Minnesota, Head of the Section of Anatomy, Mayo Clinic, Rochester, Minnesota. Paul B. Hoeber, Inc., 49 East 33rd Street, New York 16, N. Y. 1958. 901 pages. 785 illustrations. Price: $23.50.

Communicable Diseases' Transmitted Chiefly Through Respiratory and Alimentary Tracts. Volume IV. Prepared and published under the direction of Major General S. B. Hays, The Surgeon General, United States Army. Office of the Surgeon General, Department of the Army, Washington, D. C. 1958. 544 pages. Price: $5.50.

The Birth of Normal Babies. By Lyon P. Strean, M.Sc., Ph.D., D.D.S., F.A.P.H.A., Consultant, Norristown State Hospital, Norristown, Pa., Consultant Montgomery Hospital, Norristown, Pa. Twayne Publishers, Inc., 31 Union Square, New York 3, New York. 1958. 194 pages. Price: $3.95.

Neurotic Distortion of the Creative Process. By Lawrence S. Kubie, M.D. University of Kansas Press, Lawrence, Kansas. 1958. 151 pages. Price: $3.00.

The Integration of Behavior. Volume III: The Reintegrative Process in a Psychoanalytic Treatment. By Thomas M. French, M.D., Director of Research at the Chicago Institute for Psychoanalysis, University of Chicago Press, 5750 Ellis Avenue, Chicago 37, Illinois. 1958. 484 pages. Price: $10.00.

ARTHRITIC PATIENTS WANTED

The University of Wisconsin Medical School is investigating some of the metabolic aspects of rheumatoid arthritis. Dr. John Z. Bowers, Dean, asks for the cooperation of Wisconsin physicians. Doctor Bowers says, "we are anxious to study patients who have active uncomplicated disease and who have not received steroid hormones for two months. About one week of hospitalization would be necessary for the studies or they could be carried out without hospitalization." Doctor Bowers would be happy to discuss the matter with any physicians who have such patients.

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

Recent Wisconsin Licentiates

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Madison, January 13–15, 1959.

Name	*School of Graduation*	*Year*	*City*
Atterberry, R. T.	University of Illinois	1957	Madison
Baron, J. J.	National University of Mexico	1952	Milwaukee
Born, F. W., Jr.	University of Wisconsin	1957	San Francisco, California
Coffey, J. M.	Marquette University	1957	Park Forest, Illinois
Downs, D. R.	University of Wisconsin	1957	Oceanside, California
Druckery, G. R.	Marquette University	1957	Green Valley
Egyed, M. H.	University of Hungary	1940	Barberton, Ohio
Haessler, H. A.	Marquette University	1957	Milwaukee
Henschel, E. O.	University of Prague	1945	Milwaukee
Hoekstra, M. J.	University of Wisconsin	1957	Philadelphia, Pennsylvania
Hosbein, D. J.	Northwestern University	1955	Cooperstown, New York
Kalman, G. J.	University of Wisconsin	1957	Cincinnati, Ohio
Kelly, W. C.	University of Geneva	1957	Milwaukee
Kostensky, A. A.	Marquette University	1957	Dayton, Ohio
Leo, R. G.	Womens Medical College of Pennsylvania	1951	Williamsport, Indiana
Lund, L. O.	University of Wisconsin	1955	Madison
McKay, G. F.	University of Wisconsin	1955	Milwaukee
Mooney, J. C.	Marquette University	1957	Oceanside, California
Rossi, E. C.	University of Wisconsin	1954	Madison
Saydjari, M. S.	University of Geneva	1952	Brooklyn, New York
Simpson, J. F.	University of Wisconsin	1957	Brookline, Massachusetts

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, January 15, 1959.

Name	*School of Graduation*	*Year*	*City*
Blancke, F. W.	University of Amsterdam	1950	Topeka, Kansas
Boehrer, P. M.	University of Wisconsin	1954	Durand
Erickson, B. R.	Colorado University	1957	Plum City
Gargas, B. L.	Northwestern University	1946	Wausau
Garman, J. S.	Marquette University	1957	Rochester, Minnesota
Gol, Alexander	Cambridge University	1949	Chicago, Illinois
Hagel, Hans	University of Amsterdam	1953	New Britain, Connecticut
Hermans, P. E.	State University of Holland	1952	Rochester, Minnesota
Lesser, M. B.	New York Medical College	1951	Marshfield
Monk, R. S.	Northwestern University	1947	Waukesha
Shaw, W. R.	University of Illinois	1951	Wausau
Werner, J. R.	University of Basel	1939	Elderon

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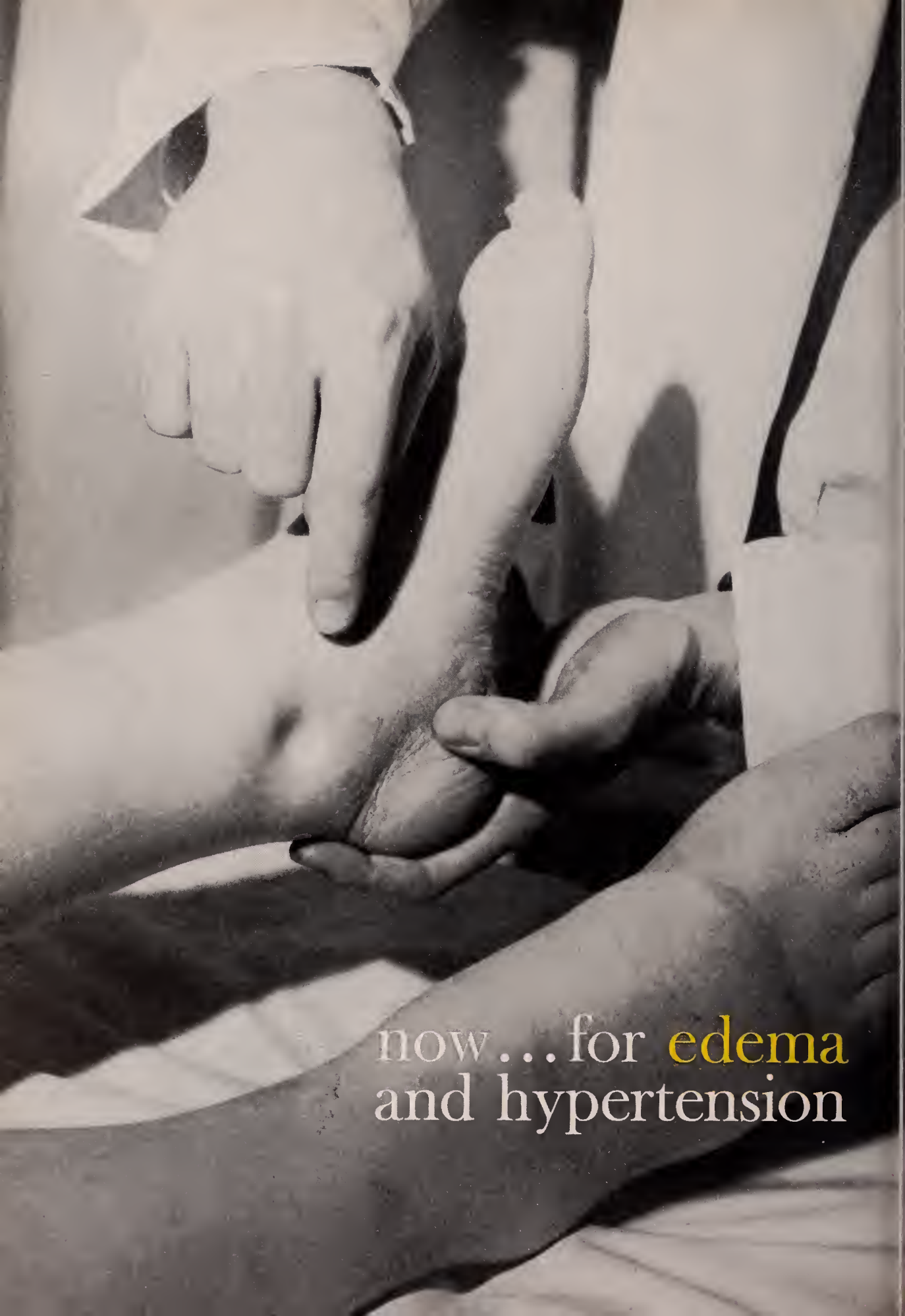
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County Society Proceedings

ASHLAND–BAYFIELD–IRON

A lecture on urethral and bladder injuries was given by Dr. John M. Streitz, a Duluth, Minnesota, urologist, at the April 22 meeting of the Ashland–Bayfield–Iron County Medical Society when 22 members, wives and guests met for dinner at the Platter in Ashland.

During the business session, *Dr. W. E. Bargholtz* was appointed to fill *Dr. F. D. Weeks'* expired post on the SMS Charitable, Educational and Scientific Foundation. The new fee schedule for the Ashland area was accepted following discussion on the subject by *Drs. J. W. Prentice, W. E. Bargholtz,* and *J. M. Jauquet.* Doctor Jauquet also reported on the recent Superior caucus meeting which he had attended.

BROWN

The April meeting of the Brown County Medical Society was held on the 9th at the Elks Club in Green Bay. A paper entitled "Surgical Diseases of the Pancreas" was presented by *Dr. Edwin Ellison,* professor of surgery at Marquette University School of Medicine.

The 50 members present authorized a Polio Vaccination Program of four injections to be given to all City of Green Bay and Brown County school children up to high school level. The program, under the supervision of the Green Bay Health Department, will begin as soon as the public health nursing staff has been strengthened.

The physicians voted a $100 contribution to the 1959 Green Bay Science Fair. A discussion was also held on the sixth district councilor resolution which was to be presented at the SMS annual meeting in Milwaukee in May.

DOOR–KEWAUNEE

The Door–Kewaunee County Medical Society met April 28 at the Stebbins Hotel in Algoma. Guest speaker, *Dr. Fred Cook* of Green Bay, addressed the group on "Problems of Anesthesiology." On the business agenda was the approval of the local medical assistants association and a report by *Dr. P. F. Lanier* on the DPT and polio immunization public relations program.

OUTAGAMIE

On April 16 the members of the Outagamie County Medical Society met to hear *Dr. Carl H. Fellner* speak on the contradictions in tranquilizer results. Doctor Fellner is an assistant professor of psychiatry at the University of Wisconsin Medical School.

PORTAGE

"Treatment of Chest Injuries" was the subject chosen by *Dr. Ben R. Lawton,* a Marshfield Clinic thoracic surgeon, when he addressed the members of the Portage County Medical Society. The meeting was held on April 14 in Stevens Point. Approximately 25 physicians were present.

RICHLAND

The Richland Hospital Library was the site of the March 4 meeting of the Richland County Medical Society. During the meeting Dr. John Rankin, Madison, delivered a speech on "Diffuse Diseases of Lung."

ROCK

The Rock County Medical Society met March 24 at the Hotel Hilton in Beloit. Dr. William F. Mengert, professor and head of the Department of Obstetrics and Gynecology, University of Illinois School of Medicine, presented a paper entitled "The Conservative Management of Abruptio-placentae." A business meeting followed and two new doctors, *Mary Berkley* and *Allen Tuftee,* were elected to membership.

SAUK

The Sauk County Medical Society met March 10th at the Hi-Way House in Baraboo. Guest speaker, *Dr. John Morrisey* of Madison, lectured on the value of transaminase tests in early diagnosis of heart and liver lesions. Present at the meeting was *Dr. John Houghton,* Third District Councilor, who talked on methods to be used in contacting legislators.

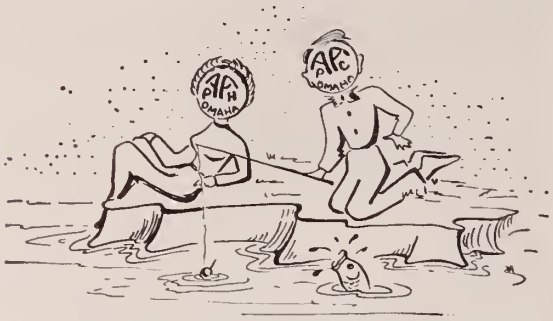
A Madison physician, *Dr. Gordon Marlow,* spoke at the Sauk County Medical Society meeting held April 14 at Uphoff's in Lake Delton. The 19 members attending also heard reports on the Third District Caucus meeting and the House of Delegates.

WALWORTH

"Recent Advances in Our Knowledge of Hormones" was the topic of speech delivered by *Dr. Mark Ciccantelli,* Milwaukee, at the meeting of the Walworth County Medical Society held March 12th at Johnny's Supper Club in Lake Geneva.

(continued)

Physicians whose names are printed in italics are members of the Society.



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SOCIETY PROCEEDINGS (continued)

Members approved having the mobile x-ray unit take chest x-rays in Walworth County again this year, but turned down the blood pressure program.

"Acute Abdominal Emergency in Childhood" was the subject of a talk delivered by *Dr. Kenneth Lemmer*, of the department of surgery at the University of Wisconsin Medical School, at the April 9 meeting of the Walworth County Medical Society. The members met at the Colonial Hotel in Delavan. Following the lecture *Dr. John Martin* reported on the Councilor's meeting which was held on April 8 in Kenosha.

WINNEBAGO

The Winnebago County Medical Society met March 5th at the American Legion Clubhouse in Oshkosh. Following dinner Drs. N. J. Smith and David Smith, pediatricians at the University of Wisconsin Hospitals, discussed "Thyroid Physiology in Childhood and Anemias in Infancy and Childhood."

On April 2 *Dr. Seymour B. Crepea*, associate professor of medicine at the University of Wisconsin, spoke at the monthly meeting of the Winnebago County Medical Society held in Menasha. He chose "The Office Diagnosis and Treatment of Seasonal Pollenosis" as the subject of his talk.

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Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met April 21 at the University Club of Milwaukee. Following dinner a scientific program featuring Dr. Ernest Jawetz, professor of microbiology at the University of California Medical Center, was offered. The topic of his address was "Reason vs. Emotion in Antimicrobial Therapy."

On May 19 the Academy members met at the University Club and had as guest speaker for the scientific program, Captain Willard R. Hawkins, USAF (MC), who discussed "The Medical Aspects of Manned Space Flight." Captain Hawkins is Chief of the Department of Biogravics, Space Medicine Division, School of Aviation Medicine, USAF, Air University, Randolph Air Force Base, Texas.

The Academy office will be closed for vacation from August 1 to September 1.

Northeastern Chapter of the AAGP

In February the Northeastern Chapter of the American Academy of General Practice held its annual meeting at Manci's in Green Bay. New officers chosen were: *Drs. Sam Brusky*, Pulaski, president; *Clarence Rothe*, Green Bay, president-elect; *Clarence Blahnik*, Peshtigo, vice-president; and *Emmett Killeen*, Green Bay, secretary-treasurer. Those elected as county delegates were: Brown, *Doctors Killeen* and *Bernard Kulkoski;* Door, *Dr. John Beck;* Kewaunee, *Drs. Henry Majewski* and *Reynold Nesemann;* Marinette, *Doctors Blahnik* and *Kenneth Pinegar;* and Oconto, *Drs. Clyde Siefert* and *Forrest Zantow.*

Wisconsin Surgical Society

New officers were elected at the annual meeting of the Wisconsin Surgical Society which was held in Milwaukee in May. They are: *Drs. Peter A. Midelfart*, Eau Claire, president-elect; *Norman O. Becker*, Fond du Lac, secretary-treasurer; *Joseph Gramling*, Milwaukee, and *John R. Steeper*, Madison, councilors; *G. N. Gillett*, Racine, delegate; and *John Conway*, Milwaukee, alternate delegate. During the meeting *Dr. James M. Sullivan* of Milwaukee was installed as president of the group.

Wisconsin Urologic Society

Dr. Benjamin H. Brunkow, Monroe, was named president of the Wisconsin Urologic Society at its annual meeting held in Racine April 11. Others taking office were *Dr. Donald W. Calvy* of Milwaukee as vice-president and *Dr. James W. Sargent* of Milwaukee as secretary-treasurer.

The scientific program included the following subjects and lecturers: "Clinical Experiences with Urethroplasty for Strictures" by *Dr. R. E. Pollard*, Milwaukee; "Ureteral Polyps Causing Hydronephrosis" by *Drs. J. W. Pick* and *C. R. Marquardt*, Milwaukee; "Some Problems in Urinary Duplication Anomalies in Childhood" by *Dr. N. B. Hodgson*, Milwaukee; "Sarcoma of the Prostate: Case Report and Review of Literature" by *Drs. U. L. Meeter* and *J. N. Richards*, Kenosha; "The Unusual Clinical Manifestations of Retroperitoneal Cellulitis" by *Dr. E. A. Stika*, Racine.

"Treatment of Retrocaval Ureter" by *Dr. R. S. Irwin*, Milwaukee; "One Stage Transvesical Prostatectomy with Primary Closure of Bladder" by *Dr. G. H. Ewell*, Madison; "Value of the Cystourethrogram as a Diagnostic and Teaching Aid" by *Drs. E. C. Bobo* and R. Rosenblum, Milwaukee; and "Interesting Ureteral Tumor" by *Dr. J. W. Sargent*, Milwaukee.

Guest speaker was Dr. Frank Hinman, Jr., Professor of Urology, University of California, San Francisco, Calif. His subjects were, "The Recurrence of Bladder Tumors" and "The Place of Splints in Ureteral Surgery."

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News of Wisconsin Physicians

Participation in WATA Annual Meeting

Wisconsin physicians who participated in the 51st annual meeting of the Wisconsin Anti-Tuberculosis Association held April 23–24 at Hotel Schroeder, Milwaukee, include:

Dr. Carl N. Neupert, State Health Officer, Madison; *Dr. Richard P. Jahn*, Medical Consultant of WATA, Milwaukee; Dr. Milton Feig, State Board of Health, Madison; *Dr. Howard Mauthe*, Radiologist, Fond du Lac; *Dr. John S. Hirschboeck*, Dean, Marquette University School of Medicine, Milwaukee; *Dr. Anthony Curreri*, Thoracic Surgeon, University of Wisconsin Hospitals, Madison; *Dr. Elmer E. Bertolaet*, Health Officer, City of West Allis; *Dr. George C. Owen*, WATA Board Member, Milwaukee; *Dr. John K. Shumate*, Superintendent and Medical Director, Lake View Sanatorium, Madison; *Dr. Stephen D. Austin*, Green Bay; *Dr. E. H. Jorris*, Assistant State Health Officer, Madison; and *Dr. Robert C. Parkin*, Coordinator of Graduate Medical Education and Assistant to the Dean, University of Wisconsn Medical School, Madison.

Joins Doege Medical Center

Dr. Henry Scott Waters is now associated with *Dr. Paul F. Doege* at the Doege Medical Center, Marshfield. Doctor Waters comes to Marshfield with a wide experience in the practice of medicine, surgery and obstetrics.

His professional background includes 10 years in the Philippines where he was medical director and chief surgeon in the Iioilo Mission hospital, and 10 years as a member partner in the Foster–Hatch Medical Group, an association of 11 other physicians in Penn Yan, New York.

Doctor Waters became a Diplomate of the National Board of Medical Examiners in 1934, and since 1940 has been a fellow of the American College of Surgeons.

The new associate in the Doege Medical Center was born in Swatow, China, of American missionary parents. His medical degree was received from Columbia University Medical School in 1932.

Racine Doctor Moves

It was recently announced that *Dr. C. W. Docter* has moved from Racine, where he had practiced for the past two years, to become associated with *Dr. E. F. Hill*, Spring Valley. Doctor Hill plans to leave Spring Valley in early summer.

New Health Officer in Mineral Point

Dr. C. L. White has been named City Health Officer of Mineral Point. He succeeds *Dr. E. J. Hohler*, who resigned from the position.

Physicians whose names are printed in italics are members of the Society.

Doctor Gouze Is Certified

A Marshfield Clinic internist, *Dr. F. John Gouze*, was recently elected as a fellow of the American College of Cardiology. He was formally inducted at the annual meeting on May 25 which was held in Philadelphia, Pennsylvania. Doctor Gouze was the first physician in the Marshfield area to be named to the College.

New Colby Clinic Started

Construction was begun in May on a new Colby clinic building owned by *Drs. J. W. Koch* and *Raymond L. Hansen*. The building will accommodate three doctors. Dr. E. D. Pfefferkorn will rejoin the group upon his release from service in August, 1960.

Doctor Rogers Taking Nuclear Studies

Dr. R. J. Rogers has been taking a three-week course at the Oak Ridge Institute of Nuclear Studies to study the application of radio active material in the clinical laboratory. He spent a week at Oak Ridge in February, another in April and will receive the third week of training in August. Doctor Rogers is the consulting pathologist of Marinette General Hospital.

Cancer Program Given in Appleton

The Outagamie County Cancer Unit sponsored a public meeting in April on the cures and effects of cancer. During the program a film, "The Other City", was presented and a panel consisting of *Drs. Frank Wright, Paul Cunningham, William Chandler*, and Mr. Richard Clark discussed cancer.

Doctor Petersen Receives Fellowship

In recognition of his work in the field of industrial medicine, *Dr. G. W. Petersen* was recently elected a fellow of the Industrial Medical Association. Doctor Petersen, medical director of the Kimberly–Clark Corporation since 1953, received his certificate at the annual meeting of the association on April 29 in Chicago.

A 1932 graduate of the University of Wisconsin Medical School, he interned at Los Angeles, California, and Brooklyn, New York. He became associated with Kimberly–Clark in 1939, leaving for three years of military service during World War II. Doctor Petersen is on the board of governors of the Central States Society of Industrial Medicine and Surgery, is a member of the American Academy of Occupational Medicine, is a member of the State Medical Society's Committee on Industrial Health and is chairman of the subcommittee on small plant industrial health programs.

(continued)

Doctor Banyai Receives Appointment

Dr. Andrew L. Banyai, Chicago, has been appointed a member of the Advisory Committee on Chest Diseases and Chairman of the respective subcommittee on research of the State of Illinois Department of Public Welfare.

THIRD AND TWELFTH DISTRICTS

Doctor Javid Lectures

Associate Professor of Surgery at the University of Wisconsin, *Dr. Manucher Javid*, spoke at a convocation on the campus of the school on March 18. His talk, "A New Approach to Reduction of Intracranial Pressure with Urea," was in conjunction with the showing of a movie presented by W.I.S.M.A.

Doctor Peterson to Washington

Dr. Edwin P. Peterson, assistant director of Mendota State Hospital, has accepted the position of clinical director at Eastern State Hospital which is located near Spokane, Washington. In addition to his duties at Mendota, Doctor Peterson has been clinical psychiatrist at the University of Wisconsin. He plans to leave for Washington in July.

UW Doctor Speaks Out of State

Dr. Edgar S. Gordon appeared as visiting lecturer at Montana State College. While there he talked on "Metabolic Problems in Clinical Medicine."

On March 10 and 11, Doctor Gordon lectured on "Lipid Metabolism, Diabetes and Atherosclerosis" at the University of Indiana Medical Center and the Eli Lilly Company in Indianapolis.

Doctor Gordon is professor of medicine at the University of Wisconsin.

Cancer Panel in Watertown

The public was invited to a cancer program sponsored by the local Cancer Society's education committee on April 5. Participants on the panel were Drs. Raymond Brown, Madison; *James Conley*, Milwaukee; and *Howard Bayley*, Beaver Dam, with *Dr. Raymond Welbourne*, Watertown, as moderator.

Doctor Curtis Addresses Kiwanis

The Beloit Kiwanis Club heard *Dr. John K. Curtis* speak on "What Progress We are Making in Heart Research" at a meeting held April 1. Doctor Curtis' knowledge of this subject stems from the fact that he is past president of the Wisconsin Heart Association, is clinical professor of medicine at the University of Wisconsin, and has done considerable research in pulmonary physiology. He is also chief of medicine and tuberculosis at the Veterans Administration Hospital in Madison. *(continued)*

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WISCONSIN PHYSICIANS (continued)

Doctor Forster Busy Lecturer

Dr. Francis M. Forster, Chairman of the Department of Neurology, attended the March 6th meeting of the Academy of General Practice which was held at Fresno, California. He spoke to the members on "Demyelinizing Diseases."

He also attended the NINDB Council Meeting in Washington during the week of March 12 and traveled to New Orleans on the 17th to participate in the American Boards of Psychiatry and Neurology examinations.

Doctor Gerol to Leave Monroe

It was recently announced that *Dr. A. Yale Gerol*, who has been neurologist at the Monroe Clinic since early 1957, will leave in June. He plans to establish an office somewhere in the Kenosha–Racine area.

Since locating in Monroe, Doctor Gerol has been active in community affairs. In January he was named Monroe's Outstanding Young Man by the Junior Chamber of Commerce.

New Ophthalmologist in Madison

It was recently announced that Dr. Fred G. Blum, Jr., has joined *Dr. Donald A. Peterson*, Madison, in the practice of ophthalmology. A native of Madison, Doctor Blum has returned to that city having spent the past six months at the Washington University School of Medicine, St. Louis, Missouri, where he held the head fellowship in retinal surgery.

Doctor Blum graduated from medical school at Washington University in 1954, interned at Delaware Hospital, Wilmington, and from 1955 to 1958 served a residency at the University of Michigan. He was in the U. S Navy Hospital Corps from 1945 to 1947.

Doctor Paul Speaks

Recently *Dr. L. W. Paul*, Chairman of the Department of Radiology at the University of Wisconsin, lectured at the Missouri State Medical Society meetings in Kansas City. *(continued)*

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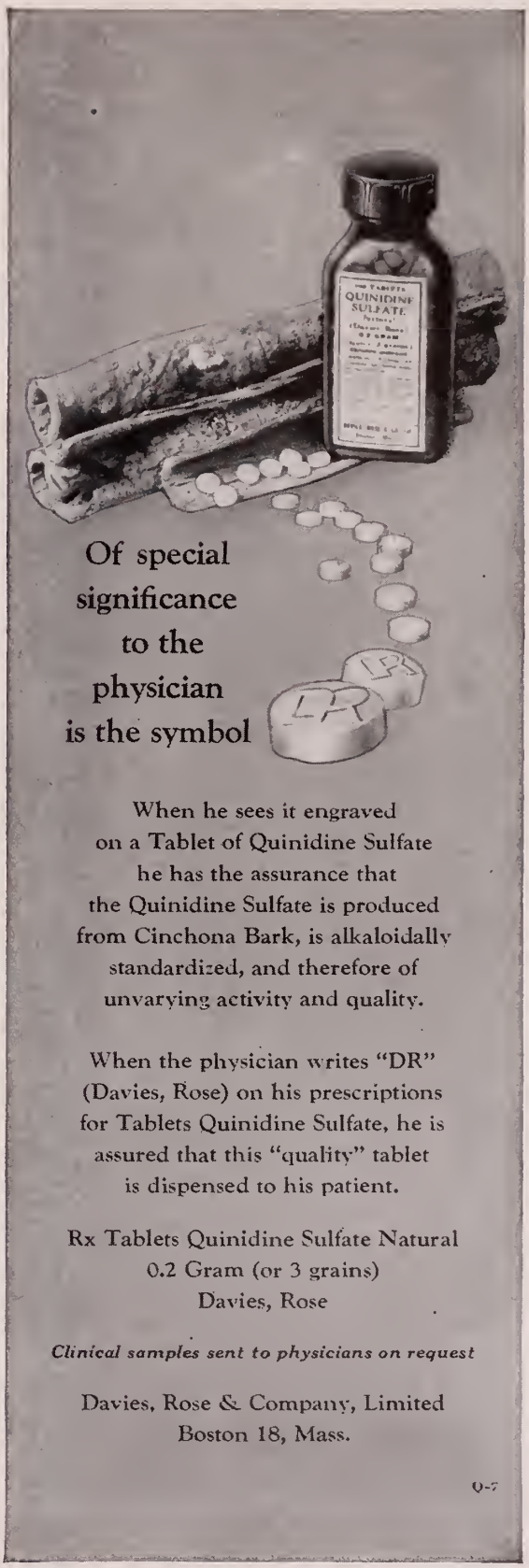

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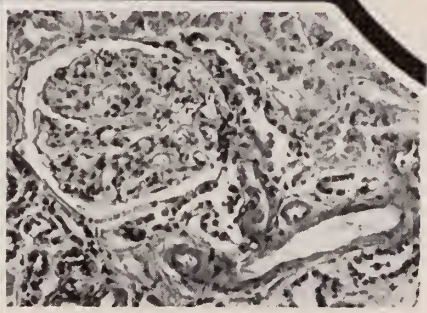

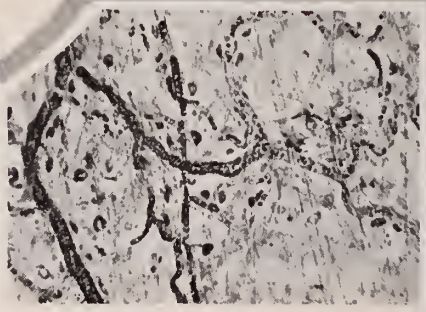

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Rautrax combines Raudixin with flumethiazide — *the new, safe nonmercurial diuretic* — for control of all degrees of hypertension. Clinicians report it safely and rapidly eliminates excess extracellular sodium and water without potassium depletion.[1-3] Potassium loss is less than with any other nonmercurial diuretic.[1] Moreover, the inclusion of supplemental potassium chloride in Rautrax provides added protection against potassium and chloride depletion in the long-term management of hypertension.

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Dosage: 2 to 6 tablets daily in divided doses initially; may be adjusted within range of 1 to 6 tablets daily in divided doses. **Note:** In hypertensive patients already on ganglionic blocking agents, veratrum and/or hydralazine, the addition of Rautrax necessitates an immediate dosage reduction of these agents by at least 50%. A similar reduction is necessary when these agents are added to the Rautrax regimen.
Supply: Capsule-shaped tablets supplying 50 mg. of Raudixin, 400 mg. of flumethiazide, and 400 mg. of potassium chloride, bottles of 100.
References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

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(1) Ernst, E. M., and Snyder, A. M.: Pennsylvania M. J. *61*:355, 1958.

(2) Preisig, R., and Landman, M. E.: Am. Pract. & Digest Treat. *9*:740, 1958.

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Doctor Nemec Moves to Cambridge

A former West Point physician and graduate of the University of Illinois Medical School, *Dr. George Nemec*, has moved his offices to Cambridge where he is associated with *Dr. James Nora*. Since release from military service last year, he had been temporarily located at the Greenwood Clinic.

Doctor Peters in Chicago Meet

"Copper and Zinc Diuresis in Neuropsychiatric Disease (Indications for Chelation Therapy)" was the title of a paper presented by *Dr. Henry A. Peters*, associate professor in the department of neurology at the University of Wisconsin, before the American College of Physicians. Their meeting was held in Chicago, April 19–24.

Doctor Hofmeister Named To Office

Dr. F. J. Hofmeister, Milwaukee, was elected a district officer of the American College of Obstetricians and Gynecologists at its seventh annual clinical meeting in Atlantic City, April 6–8. He was also named co-chairman of the district officers.

Doctor Bowers Reappointed to Committee

The Dean of the University of Wisconsin Medical School, *Dr. John Z. Bowers* has been renamed to the Medical Advisory Committee of the W. K. Kellogg Foundation. This appointment is for a one year period, ending December 31, 1959.

Hypnosis Talk Given By Doctor Cohen

An Edgerton physician, *Dr. David A. Cohen*, was guest speaker at the Milton–Milton Junction Junior Woman's Club March meeting. The topic of his talk was "Medical Hypnosis".

(continued)

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WISCONSIN PHYSICIANS (continued)

Resigns from WATA Staff

After more than sixteen years of loyal and distinctive service on the staff of the Wisconsin Anti-Tuberculosis Association, *Dr. Mary Broadbent*, Milwaukee, resigned her post on April 1. C. W. Kammeier, executive secretary of WATA, had this to say about Doctor Broadbent in the April issue of *The Crusader:* "During those years she did many things surpassingly well for the WATA. An effective speaker, she also wrote interestingly and understandably about the complex of problems that is tuberculosis. She as readily explained a diagnosis of tuberculosis to a worried patient as she interpreted many thousands of x-ray films.

"When named director of the medical department on January 1, 1958, Doctor Broadbent quickly demonstrated administrative talent. The WATA's new mobile x-ray unit is a tribute to her careful, meticulous planning.

"In devotion to duty, sense of responsibility and liking and capacity for hard work, Doctor Broadbent has been an inspiration to her associates. She and her husband carry with them the very good wishes of hundreds of Wisconsin friends, as well as of her WATA co-workers."

Psychiatry Post Accepted By Doctor Green

Dr. Joseph Green, who has served for the past three years as clinical director of the Kansas Treatment Center for Children at Topeka, Kansas, has recently moved to Madison after accepting the position of assistant professor of psychiatry on the staff of the University of Wisconsin Medical School.

A 1952 graduate of Northwestern University Medical School, Doctor Green received his psychiatric training at the Menninger Foundation in Topeka.

Doctor Young Lectures

The Wisconsin Association of Blood Banks held its annual meeting at the Veterans Administration Hospital in Madison on April 11. Among speakers at the session was *Dr. William Young*, professor of medicine at the University of Wisconsin, who demonstrated the techniques of open heart surgery.

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August 3–14, 1959

The United States Section of the International College of Surgeons will again offer its Annual Postgraduate Course, in cooperation with the Cook County Graduate School of Medicine. It will be a two-week intensive review course in General Surgery presented at the Graduate School, and in the wards and operating rooms of Cook County Hospital.

The program will include illustrated lectures, anatomy demonstrations, operative clinics and practice surgery by the participants on anesthetized dogs. Consideration will be given not only to surgical technic, surgical complications and management of the surgical patient, but also to an intensive review of the basic sciences in relation to clinical surgery.

Registrations for the course will be limited.

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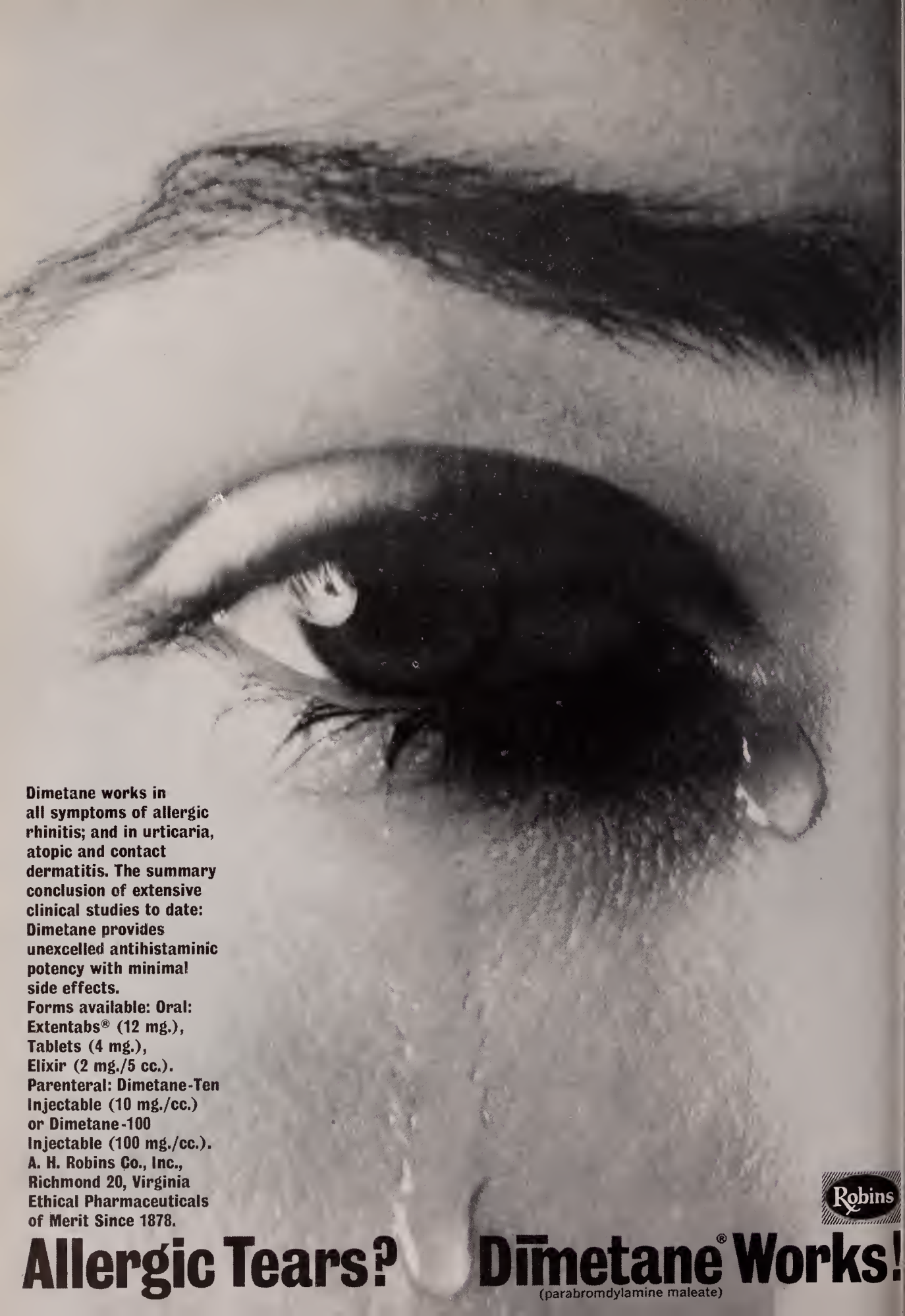
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What's New at the Medical Schools

Doctor Lemmer Honored

A University of Wisconsin surgeon has been named to receive one of the highest honors his professional colleagues can bestow upon him.

Dr. Kenneth E. Lemmer, professor of surgery in the UW Medical School, has been elected to membership in the International Society of Surgery, a worldwide group with its headquarters in Brussels, Belgium.

Doctor Lemmer

Election to the Society is on the basis of research accomplishments. Doctor Lemmer's work done at Wisconsin was reviewed by the Society and considered in his selection.

Doctor Lemmer will attend the 18th Annual Congress of the Society in Munich, Germany, Sept. 13–20, as a member of the American delegation. He and the other delegates will be in Austria Sept. 9 and 10 for a series of surgical clinics at the University of Vienna.

At the 118th annual meeting of the State Medical Society, held May 5–7 in Milwaukee, Doctor Lemmer finished his term as chairman of the Society's Council on Scientific Work, and as president of the Wisconsin Surgical Society.

A native of Spooner Doctor Lemmer received his bachelor's and medical degrees from Wisconsin. Except for his residency at the Medical College of Virginia, he has been with Wisconsin's Medical School since 1930.

Parkinson's Disease Fellowship

Ronald Grossman, medical school sophomore at Marquette, has received a student fellowship from Parkinson's Disease Foundation available for the summer months of 1959. This will enable him to study structural alterations in cases of Parkinson's disease. He will work under the direction of Dr. Andrew E. Cyrus, Jr., assistant professor of pathology. Grossman was awarded the fellowship on the basis of interest he has shown in neurology and the personal recommendation of his instructor.

Doctor Eyster Receives Award

Dr. J. A. E. Eyster, emeritus professor of physiology, University of Wisconsin Medical School, has been awarded the 1958 Senior Scientist Award by the Medical Research Association of California for "incisive, productive, and humane experimental science." In reviewing his long research career, the MRAC also praised Doctor Eyster for "inspired graduate and medical teaching, and for devotion to the advancement of medicine through "animal research."

Doctor Kory Participates in ACCP

Dr. Ross C. Kory, Associate Professor of Medicine, Marquette U., participated in a Fireside Conference on Pulmonary Function Testing at the 25th annual meeting of the American College of Chest Physicians at the Ambassador Hotel, Atlantic City, June 3–7.

First Alumni Citation Awarded

Selection of Dr. Leland S. McKittrick, professor of clinical surgery at Harvard, to receive the first Alumni Citation to a University of Wisconsin medical graduate was approved May 9 by the UW regents.

The award for "distinction in medicine" was presented to Doctor McKittrick at the Medical School's Alumni Day banquet, May 15.

Doctor McKittrick was born in Thorp and received a B.S. degree in 1915 from the University of Wisconsin. He spent two years in the University Medical School, then studied at Harvard where he received his medical degree cum laude in 1918.

He has been professor of clinical surgery at Harvard since 1948. In 1950–51, Doctor McKittrick was president of the Massachusetts Medical Society, and from 1951–58 he was a member of the board of regents of the American College of Surgeons. Doctor McKittrick now serves as chairman of the Council on Medical Education and Hospitals. He is a member of the American Surgical Association and the Society of Clinical Surgery.

National Science Foundation Awards Grant

The National Science Foundation has awarded a grant of $50,000 to Dr. Michael Laskowski, Professor of Biochemistry, to support basic research on "Proteolytic Inhibitors." The grant became effective in March, 1959, and will be for three years.

New UW Faculty Appointment

Dr. Joseph M. Green joined the staff of the University of Wisconsin Medical Center as Assistant Professor of Psychiatry on May 1. He is a 1952 graduate of Northwestern University Medical School. He attended the University of Wisconsin before entering medical school. Doctor Green has just completed a Fellowship in Child Psychiatry at the Menninger Foundation in Topeka, Kansas. Prior to that he interned at Wesley Memorial Hospital, Chicago, and held a residency in psychiatry at Winter Veterans Hospital in Topeka. Doctor Green's duties include teaching medical students and residents and the diagnosis and treatment of patients in child psychiatry. In this latter field he will work under the direction of Dr. Harold Borenz, Assistant Professor of Pediatrics and Psychiatry.

(continued)

Pathology Fellowships Awarded

Seven summer fellowships, two fellowships granted to obtain M.S. degrees, and two fellowships for predoctoral work have been awarded in the Department of Pathology. The announcement was made by Dr. Joseph F. Kuzma, Professor and Chairman of the Department, and Dr. Donald Greiff, Professor in the Department.

The fellowships have been awarded through the provision of a $108,648 training grant from the United States Public Health Service received in September, 1958. The grant is for five years ($14,472 the first year and $23,544 for each of the next 4 years).

Summer fellowship awards went to sophomore medical students: Guenther P. Pohlmann, Mary Ann Dietz, Adam Fueredi, Leo Parnagian, David Helling, Malcolm Vye, and Denis D. Faber. Students will do experimental research work on tissue culture in relation to cancer, the biophysical effect of cellular particulates, effects of new compounds on both viruses and the etiology or causative agent of typhus fever, Q fever, and the effect of radioactive materials such as strontium 90 on the production of tumors in experimental animals.

In addition to the summer fellowships, the training grant will provide assistance to two sophomore medical students, Maurice Myers and Richard Kelly, who will work half time for the next two years to obtain their M.S. degrees in Pathology. Also, predoctoral work on salivary gland viruses implicated in neonatal death is being studied by Bryan Hoerl. In September, Dr. Raymond Zastrow will begin postdoctoral work in virology under the auspices of this grant.

Doctor Angevine on Study Group

Dr. D. Murray Angevine, Chairman of the Pathology Department, UW Medical School, will serve on a study group of Host Factors in Lung Cancer. This group will be represented by a member of eight disciplines with Doctor Angevine representing Pathology. The study is being made under the sponsorship of the Advisory Committee on Research on Lung Cancer of the American Cancer Society, Inc.

Army Major Speaks at UW

Major General Elbert V. DeCoursey from the Army Medical School of Brooks Army Medical Center of San Antonio, Texas, spoke recently before the University of Wisconsin Medical School at a meeting sponsored by the Medical Education for National Defense Program. His subject was, "Medical Effects of Ionizing Radiation." In addition to medical students and faculty, the talk was heard by several physicians from the state. The meeting was held in S.M.I. Auditorium on Monday evening, May 11.

(continued)

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Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
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l-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as $CaHPO_4$)	157 mg.
Phosphorus (as $CaHPO_4$)	122 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
Manganese (as MnO_2)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.

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Pisciotta and Dessel Appointed

Dr. Anthony V. Pisciotta, Associate Professor of Medicine, and Dr. Bertram H. Dessel, Assistant Professor of Medicine, have been selected as Marquette representatives in a cooperative effort by midwestern universities and the National Institutes of Health to work jointly on research efforts in Hodgkin's disease and acute leukemia in adults. The organization is called The Mid-Western University Cooperative Chemotherapeutic Research Group. Pooled facilities and research studies, particularly with promising drugs, will form a type of registry which will unify current work in the area.

Student Article Published

"Educate, Instill, Inspire: What SAMA is Doing to Encourage Young Minds to Enter the Health Sciences," is the subject of an article by three Marquette medical students published in the May issue of the *New Physician*, national medical magazine. Authors are David H. Gasman and Benjamin W. Louthan, seniors, and Robert J. Toohill, a junior student.

Two Professors Get Fulbright Awards

Dr. James J. Smith, Professor and Chairman of the Department of Physiology, and Dr. James G. Hilton, Associate Professor of Pharmacology, have been awarded Fulbright grants, the medical school of Marquette University has announced.

Doctor Smith will do research work on the physiology of the peripheral circulation at the University of Heidelberg, Heidelberg, Germany. He expects to leave August 1 and will be gone for nine or 10 months.

Doctor Hilton has been awarded a United States Educational Grant from the State Department to be a visiting lecturer in pharmacology at the University of Arequipa, Arequipa, Peru. He will be at the University of Arequipa from June 15, 1959 to January 1, 1960.

Guidance Day a Success

Four hundred and eighty-two high school and premedical students interested in a career in the health sciences was the total count at the Vocational Guidance Day program sponsored by the Marquette chapter of the Student American Medical Association. Vocational Guidance Day, the Seventh annual one at Marquette, was held on April 18. In 1958 the total registration was 303.

Doctor Hilton Receives Grant

A grant of $3,900 has been received by Dr. James G. Hilton, Associate Professor of Pharmacology, to study "factors affecting pressor and depressor responses." The grant, effective January 1, 1959, was received from the United States Public Health Service, National Institutes of Health.

Tonometry Testing Course Given

In an effort to have all physicians make tonometry as part of their physical examination, the Department of Ophthalmology of Marquette University School of Medicine offered a special course to physicians Wednesday April 29 and Thursday April 30. Drs. Lawrence L. Garner and G. Richard Keskey, Clinical Instructors in Ophthalmology, conducted the classes. Tonometry testing is used in the diagnosis of glaucoma.

Doctor Heidelberger Named

Dr. Charles Heidelberger, Professor of Oncology, UW Medical School, has been elected to the Board of Directors of the American Association for Cancer Research, and has been appointed program chairman for the April, 1960, meeting.

Winners of SAMA–Lakeside Award

Three students of Marquette School of Medicine received second prize in the student category of the 1959 SAMA–Lakeside scientific exhibit awards at the ninth annual convention of the Student American Medical Association held recently in Chicago. Winners are Clara V. Hussey, sophomore medical student, John Harris, junior, and Kenneth Peters, sophomore. Their exhibit was titled, "Effect of Injected Thrombin on the Coagulation Factors."

On the basis of competition involving all the medical schools in the country, Marquette medical students were awarded two of twelve entries for the display of student exhibits at the national SAMA convention. The meeting was held April 29–May 2 at the Hotel Sheridan, in Chicago.

John P. Mullooly, medical school junior, displayed an exhibit on, "Chromatographic analysis of rat tissues for conversion products of injected I^{131}-labeled thyroxin."

Receives Post-Sophomore Research Fellowship

Lee R. Duffner, medical school sophomore, has received a United States Public Health Service post-sophomore research fellowship. The announcement was made by Dr. James J. Smith, professor and chairman of the Department of Physiology at Marquette. The fellowship will be available for one year beginning June 1, 1959. Duffner will use it to work toward a Master of Science degree in physiology and carry out a research program in the department under the direction of Dr. Lyle H. Hamilton, assistant professor of physiology. Research and graduate work will be carried on at the Veterans Administration Hospital, Wood, and the medical school. Duffner will study the "Inhibition of the Stress Response."

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Seek Industrial Gifts For U. W. Medical Library

Sensenbrenner Heads Drive to Raise $600,000

A drive to solicit $600,000 from business and industry toward a new $850,000 medical library on the University of Wisconsin campus at Madison has been launched by the University of Wisconsin Medical Alumni Association.

F. James Sensenbrenner, president of Sensenbrenner Paper Co., Milwaukee, is general campaign chairman for the industrial gifts drive.

Badly needed as a proper coordinate to medical education and research at the U. W. Medical Center, the library will bear the name of former medical dean Dr. William S. Middleton. He now is chief medical officer for the Veterans' Administration at Washington, D. C.

Lewis Phillips, a prominent Eau Claire businessman, has donated $50,000. He and his wife "bought" a wing of the proposed $850,000 structure.

The special gifts drive has been sanctioned both by the University of Wisconsin and by the U. W. Foundation. Medical alumni already have raised some $230,000 from a national membership of more than 4,000 doctors and technicians, according to Dr. Mischa J. Lustok, Milwaukee, alumni general chairman.

Some of the principals in the campaign to raise $600,000 from business and industry toward the William S. Middleton Medical Library at Madison are shown at the drive-launching rally April 15 at the Milwaukee University Club.

Left to right are: Dr. Einar R. Daniels, Milwaukee, president of the University of Wisconsin Medical Alumni Association, which is sponsoring the library; Dr. John Z. Bowers, Madison, dean of the U. W. Medical School; Dr. Albert G. Martin, Milwaukee, industrial chairman for the alumni group; F. James Sensenbrenner, president of Sensenbrenner Paper Co., Milwaukee, general campaign chairman; Dr. Howard J. Lee, Milwaukee, industrial chairman for the Milwaukee area, and Dr. Mischa J. Lustok, Milwaukee, general chairman of the alumni group for the drive.

Realization of the new library through normal state funds is many years away because of the priority of other construction projects for the campus, it was stated.

The current fund drive chairman for several years was state chairman in Wisconsin for the National Foundation for Infantile Paralysis and brought contributions to that fund to a peak. In announcing the medical library solicitation, Sensenbrenner said:

"Medical progress today is everyone's business. And business and industry benefit by the prompt translation of the latest medical advances to daily practice."

He described a medical library as a key factor in educating doctors and advancing the natural sciences.

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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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Medical Meetings - Postgraduate Courses

Clinical Day at VA Hospital

The Twelfth Annual Clinical Day, under auspices of the Dean's Committee of the Marquette University School of Medicine, will be held Saturday, June 27, at Veterans Administration Hospital, Wood.

PROGRAM

A. M.

8:30 Welcome Address, Mr. D. C. Firmin, Manager, VAC, Wood.

Introductory Remarks, C. P. Henke, M. D., Director, Professional Services, VAC, Wood; and John S. Hirschboeck, M. D., Dean, Marquette University School of Medicine.

8:45 Moderator: Donald A. Roth, M. D.

"Experience with Rebreathing Tube in the Prevention of Postoperative Atelectasis," by Joseph C. Darin, M. D., General Surgery.

"Diagnosis and Treatment in Pemphigus Vulgaris," by Douglas G. Burmeister, M. D., Dermatology.

"Experiences with Uretero–Ileal Transplants for Carcinoma of the Bladder," by Charles L. Weisenthal, M. D., Urology.

"Leukoplakia," by Gerald A. Kropp, D. D. S., Oral Surgery.

"Surgical Anatomy of the Diaphragm," by Yale H. Zimberg, M. D., Thoracic Surgery.

"The Selection and Preparation of Twins for Renal Transplant," by Douglas J. Coy, M. D., Medicine.

10:15 Intermission.

10:30 Moderator: John J. Frederick, M. D.

"Thyrotomy for Carcinoma of the Larynx," by Edward F. Kronschnabel, M. D., Otolaryngology.

"Pigeon Feather Hypersensitivity: Case Report of a Rare and Interesting Disorder," by Sherwood B. Stolp, M. D., Medicine.

"Tidal Drainage in Bladder Rehabilitation," by Peter D. O'Loughlin, M.D., Physical Medicine. .

"A Study of the Growth of Human Epiphyses of the Tibia and Femur," by Alfred E. Kritter, M. D., Orthopedic Surgery.

"An Evaluation of Lactic Acid Dehydrogenase Activity in the Diagnosis of Malignancy," by Edwin L. Bemis, M. D., Pathology.

"Megaloblastosis due to Dilantin," by John E. Harding, M. D., Medicine.

"Villous Adenoma of the Colon and Rectum," by James R. Keuer, M. D., General Surgery.

Mid-Summer GP Symposium In Central Wisconsin

The Wisconsin Academy of General Practice will sponsor a mid-summer medical symposium on Wednesday, July 1, 1959. The symposium, co-sponsored by Wyeth Laboratories, will offer five hours of category 1 credit.

The day-long meeting will be held at Port Edwards, just outside of Wisconsin Rapids. The scientific meetings will be held at the new Port Edwards YMCA.

All the speakers are members of the staff of the University of Minnesota Medical School. Richard L. Varco, M.D., will talk on gallbladder diseases. Doctor Varco is a professor of surgery at the U. of M. Rodney Sturley, M.D., clinical assistant professor in the department of Obstetrics and Gynecology, will lecture on "The Use and Abuse of Female Sex Hormones"; Milton Reiser, M.D., instructor, Division of Urological Surgery, will talk on "Management of Patients With Renal Shutdown"; and James Melby, M.D., instructor, Department of Medicine, will lecture on "The Changes in Infectious Disease Since the Advent of Antibiotics."

Moderators for the program will be George H. Handy, M.D., Wisconsin Rapids, who is also in charge of local arrangements; and W. A. Gramowski, M.D., Stevens Point, president of the newly formed Central Chapter of the Wisconsin Academy of General Practice.

There will be no registration fee charged for the symposium. Registration will begin at 9:30 a.m., with the lectures starting at 10:00 a.m. There will be a luncheon at 12:30 p.m. at the YMCA, for doctors and their wives, at which time the charter for the new central chapter will be presented. David N. Goldstein, M.D., President of the Wisconsin Academy of General Practice, will present the charter to Doctor Gramowski.

The scientific sessions will continue at 2:00 p.m., and will be concluded by 5:00 p.m.

A complete program of recreation for the ladies is being planned, and will include golf, swimming, and locally conducted tours.

For more information or reservations, please write: The WISCONSIN ACADEMY OF GENERAL PRACTICE, 758 N. 27th STREET, MILWAUKEE 8, WISCONSIN.

Other Dates to Remember

Oct. 23–25—32nd Annual scientific sessions of the American Heart Association, Trade and Convention Center, Philadelphia. Forms for registering and for reserving accommodations are now available from the Association, 44 East 23rd Street, New York 10, N. Y.

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Obituaries

Dr. Joseph J. Kurtin of Cudahy died April 12. He was 32 years of age.

Doctor Kurtin was born in Cudahy in 1926. He obtained his premedical education at Muhlenberg College, Pennsylvania, and later attended Temple University in Philadelphia, graduating from the Marquette University School of Medicine in 1949. An internship was completed at St. Joseph's Hospital, St. Paul, Minnesota in 1950. Following two years of general practice in Blooming Prairie, Minnesota, he began training in pathology at St. Mary's Hospital, Milwaukee, in 1952 and transferred to the Veterans Administration Hospital, Wood, in 1954 for an additional year of residency before entering the U. S. Army. Having served two years as a pathologist in Germany, he returned to Wood to complete his training. In 1958 he became pathologist at Trinity Memorial Hospital, Cudahy, and at the time of his death was director of the department of pathology there and assistant pathologist at St. Francis Hospital, Milwaukee. He also held the position of assistant professor of pathology at Marquette University.

Memberships held by him included those with The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the American Society of Clinical Pathologists, the College of American Pathologists, the Wisconsin Society of Pathologists, and was a diplomate of the American Board of Pathology, certified in both anatomical and clinical pathology.

He is survived by his widow, Ruth, and two children, Paul and Ann.

Dr. Stuart A. McCormick, 62, died unexpectedly April 15 while making rounds at a Madison hospital.

Doctor McCormick was born at Barneveld in 1896, graduated from medical school at Buffalo University in 1926, and interned at St. Mary's Hospital, Madison. In 1926 he served as Wisconsin State Prison physician at Waupun and practiced for a year at Almond before moving to Madison in 1928. A specialist in psychiatry and neurology, he was formerly physician for 10 years for the Wisconsin State Board of Control. During World War II, Doctor McCormick served for two years as chairman of the medical panel for selective service examinations and another two years in the U. S. Navy. He was also in the U. S. Army during World War I.

A member of the Dane County Medical Society, he also held memberships in the State Medical Society of Wisconsin, the American Medical Association, the Milwaukee Neuro-Psychiatric Society, and the American Psychiatric Association.

His widow, Erma; a son, John B., three daughters, six brothers and two sisters survive.

Dr. A. A. Charbonneau of Green Bay succumbed in his home on May 2 at the age of 74.

A native of Michigan, he was born in Ishpeming in 1884. Doctor Charbonneau graduated from the University of Illinois Medical School in 1910 and interned during the next year at Los Angeles County Hospital in California. In 1912 he settled in Green Bay, leaving for a short period during World War I to serve in the U. S. Army.

For a number of years he was a member of the Brown County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Charbonneau is survived by his widow and a daughter.

Dr. Joseph Meboe, a physician in Viola for the past 11 years, died May 3 as the result of injuries incurred in an automobile accident. He was 49 years of age.

He was born at Brooklyn, New York in 1910. A 1941 graduate of the University of Wisconsin Medical School, Doctor Meboe interned at the Baylor University Hospital, Houston, Texas. He served with the U. S. Army Medical Corps from 1942 through 1945 and returned to Wisconsin to practice at the Gundersen Clinic in La Crosse, going to Viola in 1948. He had served as health officer for both Viola and Liberty Township.

Doctor Meboe was a member of the Vernon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, a daughter and four sons, all at home.

Dr. H. R. Fehland, a Wausau surgeon, died May 6 at his Clear Lake summer home following a lingering illness. He was 59 years of age.

Born in 1899 at Merrill, Doctor Fehland received his medical education at the University of Wisconsin, graduating in 1922. He interned for one year at Miller Hospital, St. Paul, Minnesota, and spent the period between 1925 and 1930 in residency training at the Mayo Clinic. He had been located in Wausau since the completion of his studies.

Doctor Fehland was a member of the Marathon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was vice-regent of the International College of Surgeons, was a fellow of the American College of Surgeons, and was certified by the American Board of Surgery.

Immediate survivors include his widow, Edith, and a daughter, Mrs. Eugene Lamer, Tomahawk.

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CHANGES OF ADDRESS

B. J. Olsen, Milwaukee, to 1033 Fiedler Lane, Madison.
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G. A. Stokdyk, Santa Cruz, California, to V. A. Hospital, Temple, Texas.
J. J. Schechter, Milwaukee, to 1130 West American Street, Freeport, Illinois.
S. C. Myers, Milwaukee, to 645 Crystal Lane, Elm Grove.
H. M. Grundset, Rio, to Hartford, Michigan.
A. F. Rheineck, Milwaukee, to Route #4, Oconomowoc.
E. P. Schuh, Watertown, to 2504 West Juneau Avenue, Milwaukee.
R. B. Barrick, Green Bay, to 1201 St. Francis Way, San Carlos, California.
D. P. Davis, Vellore, N. A., South India, to 1812 Prospect Avenue, Erie, Pennsylvania.
R. E. Fitzgerald,* Milwaukee, to Tripler Army Hospital, APO 438, Box 122, San Francisco, California.
R. F. Gosin, West Covina, California, to 2441 Lofy View Drive, Torrence, California.
J. M. Markovitz, Racine, to 2215 Plymouth Avenue, North, Minneapolis, Minnesota.
B. J. Schumacher, Milwaukee, to Wilkinson Clinic, Oconomowoc.
A. M. Richter,* APO 305, New York, New York, to 2910 East Crawford Avenue, Milwaukee.

MARRIAGES

Dr. Samuel B. Harper, Madison, to Mrs. Alpha Kayser, Madison, April 10.

ARTHRITIC PATIENTS WANTED

The University of Wisconsin Medical School is investigating some of the metabolic aspects of rheumatoid arthritis. Dr. John Z. Bowers, Dean, asks for the cooperation of Wisconsin physicians. Doctor Bowers says, "we are anxious to study patients who have active uncomplicated disease and who have not received steroid hormones for two months. About one week of hospitalization would be necessary for the studies or they could be carried out without hospitalization." Doctor Bowers would be happy to discuss the matter with any physicians who have such patients.

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DANE

The Mendota State Hospital, Madison, was the site for the June 25 meeting of the Dane County Medical Society. Activities started at 3:00 p.m. with a picnic, dinner, tour of facilities, and sports events for members.

New members elected to the Dane County Medical Society include: Drs. Fred G. Blum, Jr., John Morledge, *George Nemec, Jr.*, Andrew B. Crummy, Lawrence O. Lund, Theodore C. Smith, and Sherwyn M. Woods.

Doctor Blum is associated with *Dr. D. A. Peterson* in ophthalmology with his special interest being retinal detachments and retinal diseases. Doctor Morledge is associated with the Jackson Clinic as an internist with a specialty of cardiology. Doctor Nemec, formerly of Clark County, has transferred his membership to the DCMS and is practicing in Cambridge. Doctor Crummy has returned to the University Hospitals for a residency in radiology. He also took his internship there. Doctor Lund has also returned to the University Hospitals following two years of service and will take a postgraduate course. Doctor Smith is taking a residency in anesthesiology at University Hospitals where he also interned. Doctor Woods is taking a residency in psychiatry at University Hospitals following his graduation from the UW Medical School and internship at Philadelphia General Hospital, Philadelphia.

Physicians whose names appear in italic are members of the Society.

TRI-COUNTY MEDICAL MEETING

Members and wives of medical societies of Walworth, Racine and Kenosha counties met June 17 at the Racine Country Club for a scientific session and social gathering. The scientific meeting, held from 10:00 a.m. to 12:00 noon, included a panel discussion on metastatic cancer. Panelists were *Drs. A. R. Curreri* and George M. Maxwell, of the University of Wisconsin Medical School, and *Drs. Maurice Greenberg* and *Edwin H. Ellison*, of the Marquette University School of Medicine.

Following luncheon the doctors played golf. The wives played golf in the morning and cards and other planned activities in the afternoon. All enjoyed dancing in the evening.

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Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology held a scientific and business meeting May 16 and 17 at St. Vincent's Hospital, Green Bay. Guest speakers were Dr. Kenneth C. Johnston of Chicago and Dr. Thomas P. Kearns of the Mayo Clinic, Rochester, Minn. Doctor Johnston's topics were: *"Respiratory Obstruction in the Newborn"* and *"Management of Laryngeal Trauma."* Doctor Kearns talked on *"Some Neurological Disorders of the Extraocular Muscles"* and *"Neurology and the Eye."* A tour of St. Vincent's Hospital and a demonstration of the hearing aid evaluation center at the Green Bay curative workshop completed the meeting.

Milwaukee Neuropsychiatric Society

The annual meeting of the Milwaukee Neuropsychiatric Society was held Wednesday, May 20. Officers elected for the year 1959–1960 are as follows:

President: *Dr. C. J. Buscaglia*
Vice–president: Dr. George J. Martin
Secretary-Treasurer: *Dr. Henry Veit*
Councilors: *Dr. Edward C. Schmidt, Dr. David Cleveland*

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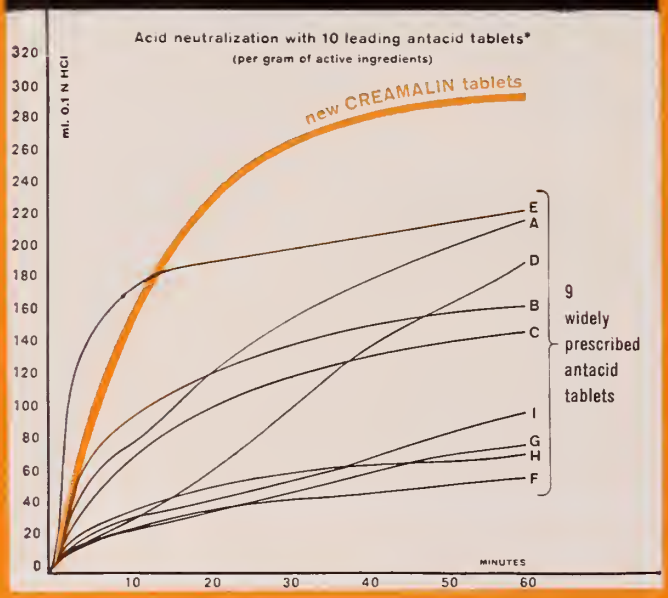

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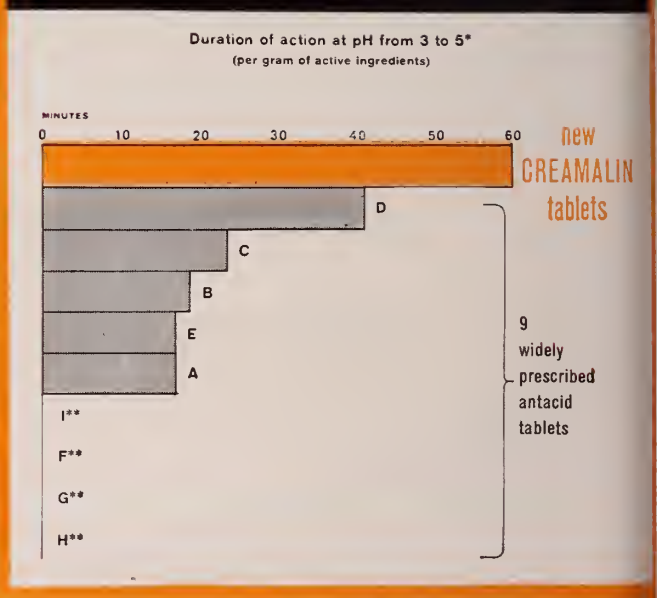

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Marshfield Clinic Expansion

Completion of a million-dollar building expansion program of the Marshfield Clinic at Marshfield was marked by an open house on March 1. Approximately 2,000 persons, coming from as far as 125 miles, were taken on a tour of the four-story addition. The addition, which virtually doubles the space previously available at the medical institution, is shown at the right in the picture below. The original building, with its new front, is shown at the left.

Founded in 1916 by six physicians, the Clinic now has 35 professional men on its staff and about 130 employees. With this basis, it ranks eighth or ninth in size among the 700 similar clinics in the United States.

An average of 300 persons register at the institution each week, mainly from northern and central Wisconsin, Upper Michigan and lower Canada. However, the Clinic reports that patients come from every state in the Union, including the newest state, Alaska.

Last year more than 72,000 patients registered at the Marshfield Clinic, and more than 180,000 medical histories have accumulated since its founding.

Named to Eye Care Foundation

Dr. George Nadeau, Jr., Green Bay, was recently named Wisconsin district member of the Board of Councilors of the National Foundation for Medical Eye Care.

Melrose Has Clinic Facilities

A grand opening celebration of the new Krohn Clinic at Melrose was held February 4. The new Clinic is a branch of the Krohn Clinic and Hospital of Black River Falls. The Melrose office was first opened in the fall of 1956 at the request of various citizens in the village. A physician from the Krohn Clinic staff conducted office hours in Melrose two half days a week until the new Clinic was built. This new clinic building, constructed to meet the medical requirements of the people in the area, contains a large reception room, two consultation offices, x-ray department with dark room, optical department, laboratory, and business office. With this increased space service has been expanded to three half days per week for physicians.

The Krohn Clinic and Hospital also offers the same service to residents at Alma Center where it purchased an office building. These branch services have eliminated the necessity of the Melrose and Alma Center communities to seek physicians on their own.

The Krohn Clinic and Hospital medical staff includes: *Drs. Robert Krohn, John R. Marks, John Noble, Roland Thurow, Richard Holder*, and *John I. Krohn.*

Burlington Gets New Physician

Having recently completed a tour of duty with the U. S. Navy, stationed at Pensacola, Florida, San Diego, California, Japan, the Philippines, and Hong Kong, Dr. Robert C. Wheaton joined the Mastalir–Baker Clinic at Burlington in March. Doctor Wheaton graduated from the University of Wisconsin Medical School and interned at the University of Texas medical branch hospital in Galveston, Texas.

Dr. Patricia Lanier Lectures

A talk on the biological changes of old age entitled "Facing the Inevitable" was delivered by *Dr. Patricia Lanier*, Kewaunee, on May 13 at the meeting of the American Association of University Women in Appleton. Doctor Lanier stressed that one of the major factors in adjusting to old age is overcoming boredom.

Blue River Observes "Dr. Randall Day"

On April 5 a day was set aside in honor of *Dr. Murray W. Randall*, Blue River, who was retiring. He had practiced in the area since 1914.

Speakers on the program were: *Dr. Emery Randall*, son of the honored guest; *Dr. H. W. Carey, Dr. L. M. Pippin*, and two local ministers. The Blue River High School band and a soloist provided the entertainment. At the conclusion of the event which 750 attended, Doctor Randall was presented with a money gift from the community.

Doctor and Mrs. Randall are now residing in Glenwood Springs, Colorado, where they are operating a motel.

(continued)

Physicians whose names are printed in italics are members of the Society.

Three Doctors Attend Conference

A three-day medical clinical conference held at the Mayo Clinic, Rochester, Minn., during April was attended by *Drs. J. S. Mubarak*, Tomah; *Dewitt Beebe* and *Harry Mannis*, both of Sparta. The clinic provided details of the latest advances in medicine and surgery.

Doctor Balder Addresses Hospital Guild

On March 31 *Dr. Roy B. Balder* discussed the advantages and services of a small community hospital over the large city hospitals with which he has been acquainted. His talk was delivered at the Hospital Guild meeting held at the Hillsboro Hospital. He placed special emphasis on the differences in the maternity ward.

Whitehall Physician Donates Instruments

Dr. R. L. MacCornack, Whitehall, recently presented the Whitehall Community Hospital with several thousand dollars worth of surgical and diagnostic instruments and x-ray equipment. He is shown below with the instruments.

Dr. R. L. MacCornack

Doctor MacCornack, who is in semi-retirement after 40 years of practice, served as president of the hospital's board of directors for over 30 years and is still a member of the directing board.

The gift to the hospital was made following the sale of the Whitehall Clinic building to a group of Whitehall businessmen.

Since Doctor MacCornack came to Whitehall following World War I, he has performed over 4,000 major surgical operations with the instruments he has given to the hospital. He has performed 1,100 of these operations in the past five years, not counting the thousands of minor surgical operations.

Participants in NTA Meeting

Eight Wisconsin persons, including three physicians, participated in the annual meeting of the National Tuberculosis Association held in Chicago May 24–29.

"The Influence of Increased Intra-alveolar Pressure on the Uptake of Carbon Monoxide by the Lungs and on the Diffusing Capacity of the Pulmonary Membrane and Pulmonary Capillary Volume in Man" was the topic presented by Theodore C. Smith, M.D., resident in anesthesia, Cardiopulmonary Research Laboratory, UW Medical School; John M. Ramlo, D.D.S., student research assistant, UW; Richard A. Cooper, B.S., student research assistant; Carl B. Weston, B.S., student research assistant; and John Rankin, M.D., assistant professor of medicine, Cardiopulmonary Research Laboratory, Department of Medicine, University of Wisconsin, Madison.

Helen A. Dickie, M.D., professor of medicine, UW Medical School, Madison, was co-chairman of a session on tuberculin testing. John E. Jacobs, Ph.D., manager, Advanced Engineering Laboratory, X-ray Department, General Electric Co., Milwaukee, was a member of the booth on "The TV-X Cine-radiographic Unit." E. Dale Trout, D.Sc., Consulting Radiation Physicist, General Electric Co., Milwaukee, presented a report on "Radiation Protection" during the session on "Patterns for Detection."

Clinic Opened in Gays Mills

The members of the Hirsch Clinic of Viroqua have opened a branch in Gays Mills. The three physicians, *Drs. R. S. Hirsch, R. A. Starr* and *H. E. Oppert* will rotate their time at the clinic. In addition a registered nurse will be on duty at the new branch from Monday through Friday.

Elmwood Doctor Returns from Trip

Dr. Frank Springer of Elmwood returned in March from a month-long flying trip in Africa. While on a safari he shot a 10,000-pound elephant, and when fishing for Nile perch, he had a stout leader cleanly bit in two by a tiger fish. Doctor Springer visited with two Wisconsinites, Dr. Ervin Buss, a zoologist from the University of Wisconsin, and his wife, who are stationed at Mesinduchi in Binoro doing research work.

Watertown Physician Has Editorial Post

It was recently announced that *Dr. Wallace Marshall*, Watertown, has been appointed as Book Review Editor of the Mississippi Valley Medical Journal. Doctor Marshall is author of the book "Essentials of Medical Research" and has written numerous medical and surgical research articles published in U. S., Canadian and Indian medical journals.

(continued)

Doctor Pfeifer Day

Grateful and loyal residents of New London set aside June 6 to honor their beloved doctor and friend, *Dr. Fred J. Pfeifer.* In appreciation of his 50 years of devoted service to the community, New London celebrated "Doctor Pfeifer Day" with a huge parade in the afternoon followed by a "This Is Your Life" program and a dinner in the evening.

The entire community of 5,000 participated in the celebration which was climaxed with the presentation of a new station wagon to the "Good Doctor." One of the highlights of the day's festivities was the presence of nearly 800 men, women, children and infants of the nearly 4,000 babies he has delivered in those 50 years.

The 71-year-old general practitioner was born November 30, 1878, in Plymouth where his father was a leading druggist. Doctor Fred, as he is called by his many patients and friends, worked his way through three years of college at the University of Wisconsin with the intention of becoming a physician. Because of the lack of funds, he quit school to do some teaching. Later he picked up his books again and completed his medical education in 1909 at Wisconsin College of Physicians, which is now Marquette University.

His first location was at Zachow, but the death of Dr. H. L. Bacon, New London, while deer hunting in the north woods, changed his plans. Doctor Pfeifer was persuaded to come to New London to "look over the field." He has been there ever since. That was in November, 1909.

In 1914 he went to Europe with the American Surgeons Clinical Tour to spend a year in study at Vienna and Berlin. His route home was through Canada where he had an opportunity to visit several hospitals.

That started a determination to see a hospital in New London. He began by setting up a five-room hospital in his home in 1922. This lasted for 20 years. In 1931 a new 50-bed community hospital was opened to patients largely through the efforts of Doctor Pfeifer and the efforts of other residents.

During the influenza epidemic in New London in 1918 he displayed his amazing stamina by working two weeks without a night's sleep or a change of clothes. He slept in the car between house calls.

Doctor Pfeifer has been a crusader for public health and throughout the years has carried with him a lot of authority and respect in combating diseases. He was one of the pioneers in promoting low cost and free clinics for inoculations and vaccinations. He has advocated immunization to disease even before he became a public health officer in New London in 1924. He was one of the first *not* to be satisfied with the quarantining of contagious diseases but insisted that something should be done to help the public guard against contracting diseases.

Dr. Fred J. Pfeifer

It was about a year after he started this work that the Wisconsin State Board of Health made it a regular order of business. He prepared a chart on infectious and contagious diseases mostly for mothers and teachers. The chart names the diseases, gives the principal signs and symptoms of each, its method of infection, incubation period, dates of definite illness, infection cases and remarks. The charts were deemed of such marked merit and value that one was placed by the authorities in every home and school in the city of New London January 1, 1916. This, of course, was before Wisconsin had laws regulating the diseases.

His contributions to civic projects have been many and varied. His sports enthusiasm through the years has prompted the New London city council to dedicate its newest park in his honor.

Life devoted six pages in its June 22 issue to "Doctor Pfeifer Day."

The State Medical Society at its 118th annual meeting in Milwaukee on May 6 honored Doctor Pfeifer as one of the "Fifty Year Club" members of the Society.

Doctor Pfeifer's long years of service have been highlighted by the generosity of both his personal finances and his never-ending quest for finding and using the newest methods possible in curing physical ills. His community refers to him lovingly as their most dedicated citizen.

THIRD AND TWELFTH DISTRICTS

Has Post in Allergy Society

Dr. Bert B. Schoenkerman, Milwaukee, was named president-elect of the Chicago Society of Allergy at its last meeting. He had previously been secretary-treasurer of the Society.

A First VP in WATA

Dr. Carl N. Neupert, state health officer, Madison, moved up to the first vice-presidency of the Wisconsin Anti-Tuberculosis Association following election at the annual business meeting on May 23. *Dr. O. A. Sander*, Milwaukee, is president and *Dr. Elwood W. Mason*, Milwaukee, is secretary. Other physicians on the board of directors are: *Henry A. Anderson*, Stevens Point, *George C. Owen*, Milwaukee, *James M. Wilkie*, Madison, *Einar R. Daniels*, Milwaukee, and *Helen A. Dickie*, Madison.

Doctor Preizler Speaks

Dr. Josef Preizler, state epidemiologist, Madison, gave a talk on "Diseases Acquired in Swimming" during the ninth biennial short course for swimming pool and beach directors and operators from all parts of the state held June 4 and 5 in McCarty Park, Milwaukee. Staff members of the Wisconsin State Board of Health conducted the course which was co-sponsored by the League of Wisconsin Municipalities, the Milwaukee City Park Commission, and the Milwaukee City Health Department.

Two Eye Clinicians Attend Meetings

Drs. Matthew D. Davis and *Peter A. Duehr*, two Madison associates, recently attended meetings out of state. Doctor Davis was present for the Ninth Annual Meeting of the New Orleans Academy of Ophthalmology and Doctor Duehr attended the 18th Clinical Meeting of the Wilmer Residents Association at the Wilmer Ophthalmological Institute in Baltimore, Maryland.

In addition to their Madison practices, the physicians are on the ophthalmological staff of the University of Wisconsin Medical School with Doctor Duehr being professor of surgery and Doctor Davis being assistant clinical professor of surgery.

Doctor Reese in Japan

Dr. Hans Reese, professor of neurology at the University of Wisconsin, left for Japan in April to do a six months' study on multiple sclerosis as a special consultant to the Institute of Neurological Diseases and Blindness. He will spend three months at the University of Fukuoda and the remainder of the time at the Universities of Niigata and Sapporo.

(continued)

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE FRANK, M. D.
WILLIAM C. JANSSEN, M. D.
LOREN J. DRISCOLL, M. D.

JOSEF A. KINDWALL, M. D.
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LEROY A. WAUCK, Ph. D.
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Cancer Education Program in Madison

The Dane County Unit of the American Cancer Society presented a cancer education program to several Madison business firms and city and county employees in March. *Dr. Robert A. Straughn*, Madison, answered questions at the end of the afternoon meeting. Doctor Straughn is a member of the cancer committee of the Dane County Medical Society.

Dr. S. A. Morton Gives Talk

Dr. S. A. Morton, Milwaukee, discussed communications to and from the physician before the Hospital-Medical Section of the International Council of Industrial Editors May 28, at the Hotel Schroeder in Milwaukee. Doctor Morton is past president of The Medical Society of Milwaukee County, a member of the Society's board of directors and editor of its monthly magazine, the *Milwaukee Medical Society Times*.

Doctor Morton appeared on a panel with Alex Dworkin, public relations director, Michael Reese Hospital, Chicago, and David Goodman, press relations representative, General Electric X-Ray Department, Milwaukee.

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[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

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What's New at the Medical Schools

Marquette Alumnus of the Year

Dr. Max J. Fox, a member of the faculty of Marquette University School of Medicine since his graduation from its medical school in 1922, was named "Marquette Alumnus of the Year" at a dinner for past presidents of the Alumni Association on May 14. He received a citation at Marquette's commencement exercises June 7. Doctor Fox was cited for his achievement of national renown as a physician, for his extensive work, investigation, and teaching in the field of infectious diseases, and for his devotion and efforts as an alumnus of the University.

Doctor Fox

After receiving his M.D. degree from Marquette, he interned at Milwaukee County Hospital and subsequently became a resident physician at Southview Hospital in 1923. Since 1929 he has been its medical director. He has also served as contagious disease diagnostician and consultant for the city of Milwaukee since 1923. Doctor Fox is an Associate Clinical Professor of Medicine at Marquette.

Doctor Fox is often referred to as "Mr. Marquette" because of his devotion to the University. As president of the Medical Alumni Association he was a leader in raising funds for the basic science building addition of the medical school which houses the medical–dental library. In 1953 he was named Marquette Medical Alumnus of the Year by the Medical Alumni Association.

Outpatient Clinic Services Changed

Effective July 1, the clinical services provided directly by Marquette University School of Medicine were consolidated and changed. The clinic for the diagnosis and special study of glaucoma has been expanded. Services are provided without charge to those unable to pay. Pathologic examination and diagnosis of ophthalmologic tissue are being continued. Refraction for glasses as well as diagnosis and therapy of ophthalmologic disesase in general have been discontinued. Clinical radioisotope services also have been discontinued.

Doctor Stoddard Receives Award

Dr. F. Jackson Stoddard, Associate Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine, received the Phi Chi Teaching Award at the Honors Convocation at the medical school on May 20. The award has been presented annually since 1952 by the Epsilon Chi chapter of Phi Chi to the outstanding clinical lecturer. He is selected by vote of the entire junior class of the medical school. Doctor Stoddard also received the award in 1955.

Doctor Shideman Elected Treasurer

Dr. F. E. Shideman, Chairman and Professor of Pharmacology, University of Wisconsin Medical School, was elected treasurer of the American Society for Pharmacology and Experimental Therapeutics at its meeting this spring in Atlantic City, N. J.

Doctor Botham to Meeting

Dr. Richard J. Botham, Instructor in Surgery, UW Medical School, attended a meeting of the American Association of Thoracic Surgery held in Los Angeles, California, in April.

Wins Honor Award in Photography

Anthony Kuzma of the Department of Art and Photography, Marquette University School of Medicine, received an honor award for excellence in medical photography to outstanding photographs in the scientific print salon at the first midwestern sectional meeting of the Biological Photographic Association held in Iowa City, Iowa, April 24 to 26.

Honorary Degree to Doctor Bowers

Dr. John Z. Bowers, dean of the UW Medical School, received an honorary Doctor of Science degree from the University of Maryland at Commencement exercises, College Park, Maryland, on June 6. Doctor Bowers has also been appointed a member of the Committee on Extension and Policy at the Alpha Omega Alpha Honor Medical Society.

Doctor Angevine Attends Meetings

Dr. D. Murray Angevine, professor and chairman, Department of Pathology, UW Medical School, attended a meeting of the National Research Council Committee on the Skeletal System in Washington D.C., on May 25. On June 3 he attended a meeting of the Advisory Committee on Research on the Pathogenesis of Cancer, a Committee of the American Cancer Society.

Attends Pennsylvania Meeting

Dr. Charles W. Crumpton, associate professor, Department of Medicine, and director of the cardiovascular research laboratory, UW Medical School, attended the meeting of N.I.H. Cardiovascular Directors held during the first weekend in June at Hershey, Pa.

(continued)

Marquette Doctors Receive Grant

Dr. Derward J. Lepley, Clinical Instructor in Surgery, and Dr. Paul F. Hausmann, Assistant Clinical Professor of Surgery, Marquette University School of Medicine, have received a $50,018 grant from the National Heart Institute of the United States Public Health Service for work on "The physiology of the infundibulum of the right ventricle." The grant covers a period of three years from May 1, 1959 through April 30, 1962. Research will be done at the medical school and at Milwaukee Children's Hospital.

Exchange of Senior Surgical Externs

Five senior medical students from Marquette University School of Medicine have been accepted by the Department of Surgery as exchange students in surgery with Ohio State University, Dr. Edwin H. Ellison, Professor and Chairman of the Department of Surgery, has announced. The students are Frederick G. Dettmann, Patrick J. Clark, M. Therese Southgate, Gerald T. Roling, and Andrew F. St. Amand.

The exchange program has been approved by the administrative officers in both schools. Students going to Ohio State will work under the direction of Dr. Robert M. Zollinger, Professor and Chairman of the Department of Surgery. Students will be assigned to Ohio State for two months, in lieu of the two month surgical externship existing for students in the present curriculum at Marquette.

First Annual Surgical Staff Banquet

Honored at Marquette's first annual surgical staff banquet held at the Wisconsin Club, Milwaukee, May 13 were Dr. Frederick A. Coller, Dr. Carl W. Eberbach, Dr. F. Gregory Connell, and 15 surgical residents completing their postgraduate training at Milwaukee County Hospital and the Veterans Administration Hospital.

Doctor Coller, Professor of Surgery, Emeritus, at the University of Michigan School of Medicine, was the first person to become the Adolf Gundersen Visiting Professor at Marquette from May 11–13. Doctor Gundersen is the late father of three La Crosse physicians: Gunnar, immediate past president of the American Medical Association, Alf H., and Sigurd B.

Doctor Eberbach is a Clinical Professor of Surgery at Marquette and was chairman of the Department from 1950 to 1958. He has been on the faculty since 1927.

Doctor Connell, an Oshkosh physician, was honored for his initial work which led to the development of safe anastomosis of the gastrointestinal tract (Connell suture).

Doctor Eberbach and residents honored received caricatures of themselves drawn by Robert Albertin, Medical Illustrator in the Department of Surgery.

Woman to Edit Marquette Medical Review

For the first time in its history, the *Marquette Medical Review* will be edited by a woman student. M. Therese Southgate, a senior, was elected editor-in-chief of the scientific quarterly which is published by students of Marquette University School of Medicine. She will edit the silver anniversary issue.

New Chairman History of Medicine

Dr. Gernot B. Rath, of the University of Bonn, Germany, has been appointed chairman of history of medicine in the University of Wisconsin Medical School. The appointment is effective next January 1 when Doctor Rath will return to Wisconsin from Germany.

Doctor Rath, who will have the rank of associate professor, has been visiting professor of medical history during the second semester of the 1958–59 school year.

Doctor Rath studied medicine at the Universities of Marburg, Hamburg, Berlin, and Bonn. He obtained his medical degree at Bonn in 1948, and then turned to the study of the history of epidemics, anatomy in the Middle Ages, and medical writing in the 16th and 17th centuries. He is regarded as an international authority in these fields.

The Wisconsin Medical School was a pioneer in the field of medical history teaching and research, setting up a department for that purpose in 1950.

Two other European-trained scholars have participated in the program. Dr. Erwin H. Ackerknecht served as chairman from 1950 to 1957. He came to Wisconsin in 1947 as the first professor of medical history in the Medical School.

Dr. Walter Artels, of the University of Frankfurt, was visiting professor of the history of medicine in 1958.

Wisconsin Medical Alumni Citation

One of the nation's foremost surgeons, Dr. Leland McKittrick, Clinical Professor of Surgery at Harvard University, received the first Alumni Citation presented by the Wisconsin Medical Alumni Association. The award was presented to Doctor McKittrick by Conrad Elvehjem, President of the University of Wisconsin, for his contributions to medicine and to the Alumni Association at the fourth annual meeting of the Alumni Association in Madison, May 15. In his acceptance speech, Doctor McKittrick, a pre-med student at the University from 1911 to 1916, recommended doing away with pre-med schools as a means of broadening the base for selection of medical students. He recommended that potential medical students be drawn from those engaged in broader educations, including the humanities. From these groups, the best should be gotten for medical students.

(continued)

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Grants Received

A grant of $100,000 from the Rockefeller Foundation has been received by the University of Wisconsin Medical Center for the expansion and development of the Medical Genetics Program. The funds will allow the department to add new members to its staff and to broaden the program of teaching and research. New research facilities of the department will be housed in the research addition to S.M.I. now under construction. Additional apparatus and equipment for these quarters will be provided by the grant.

Dr. Richard A. Lende, a Resident in Surgery at the UW, is the recipient of a Sister Kenny Foundation scholarship grant of $35,000 for research in the localization of motor and sensory function in the human cortex. Doctor Lende's appointment, effective July 1, will continue for five years under the grant. One other Wisconsin man, Dr. Wallace Welker, Instructor in Physiology, holds a Sister Kenny scholarship grant.

Dr. James L. Way, Assistant Professor in Pharmacology and Toxicology at the UW, was granted a Senior Research Fellowship by the Public Health Service for a period of five years. This fellowship began July 1, 1959, and will cover research expenses for Doctor Way in addition to the fellowship. Doctor Way's research interest is in the area of metabolic alteration of alkylphosphate antagonists and the application of cytochemical and histochemical methods of pharmocological investigations.

UW Faculty Honors

John Z. Bowers, Dean of the University of Wisconsin Medical School, received an honorary Doctor of Science degree from the University of Maryland at Commencement exercises, College Park, Maryland, June 6, 1959. Doctor Bowers has also been appointed a member of the Committee on Extension and Policy at the Alpha Omega Alpha Honor Medical Society.

The newly formed Central Society for Pediatric Research has elected Dr. Nathan J. Smith, Professor and Chairman, Department of Pediatrics, as its first president.

The Interdepartmental Committee on Nutrition for National Defense has sent a team of specialists in the field of nutrition to Ecuador to conduct a nutrition survey of their Armed Forces and selected civilian groups this summer. Dr. F. E. Shideman, Chairman and Professor of Pharmacology and Toxicology, was invited to serve as a clinician on this team. The group left July 1 and will return by mid-September. Doctor Shideman was in Washington, D. C., May 17–19 to attend the briefing sessions for the trip.

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Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.

Preston W. Thomas, M. D.

Medical Meetings - Postgraduate Courses

Annual Assembly Wisconsin GPs

The Eleventh Annual Assembly of the Wisconsin Academy of General Practice will be held September 20–22 at the Milwaukee Auditorium. Twelve hours of Category I credit for members is authorized.

September 20 (Sunday) will be devoted to meetings of the House of Delegates and the Board of Directors.

Doctors may register at the Plankinton Hotel on Sunday or at the Auditorium Monday morning, September 21. There is no registration fee.

Fourteen speakers from all over the country will offer a general scientific program.

Monday evening, September 21, Philip Thorek, M.D., Chicago, will address a banquet at the Plankinton Hotel on "Food For Thought".

A complete program for physicians' wives is planned, including a luncheon and style show at Mayfair Shopping Center.

For more information, contact: Wisconsin Academy of General Practice, 758 N. 27th St., Milwaukee, 8, Wisconsin.

Fall Cancer Symposium at UW

The Fifth Annual Fall Cancer Symposium at the University of Wisconsin Medical Center will be held on Saturday, October 24, in Madison. The scientific program will be conducted from 9:00 a.m. to 12:00 noon. Dr. Lauren Ackerman, pathologist, of St. Louis, Mo., will be the guest lecturer. There will be lunch before the football game between Wisconsin and Ohio State. The symposium is co-sponsored by the Wisconsin Division of the American Cancer Society and the Cancer Research Section of University Hospitals.

Wisconsin Society of Internal Medicine

The fall program of the Wisconsin Society of Internal Medicine will be held September 19 at the Marshfield Clinic, Marshfield. The program follows:

9:00 a.m. Registration

9:30 a.m. *The Lente Insulins*
R. S. Baldwin, M.D., Marshfield

9:45 a.m. *Symposium on Chest Diseases*
Moderator: Helen R. Dickie, M.D., Madison
Participants: Michael L. Furculow, M.D., Kansas City, Kansas; John K. Curtis, M.D., Madison; Ben R. Lawton, M.D., Marshfield; and G. E. Magnin, M.D.

12:30 p.m. Lunch and election of officers.

2:00 p.m. William S. Middleton Lectureship
Fungus Diseases of the Chest
Michael L. Furculow, M.D.

3:00 p.m. Business meeting.

4:30 p.m. Adjournment.

Diseases of Animals Transmissable to Man To Be Discussed at Conference

As a result of a number of preliminary meetings of physicians, veterinarians and public health practitioners in 1957, it was decided that the growing importance of infectious disease in practice warranted a conference on the diseases of animals transmissable to man. Many sections of the United States have successfully presented a regular conference of this nature. Consequently, it was decided to hold an annual conference which was initiated by a well-attended meeting in 1958 at Omaha, Nebraska.

This year the second annual Midwestern Interprofessional Conference on Diseases of Animals Transmissable to Man will be jointly sponsored by the College of Medicine, The State University of Iowa, and the Iowa State Department of Health at Iowa City on September 10 and 11. The subjects to be covered will include brucellosis, rabies, leptospirosis, Q fever, staphylococcal diseases and others. Presentations will be made by veterinarians and physicians and will emphasize the public health practical aspects, and recent advances in these fields.

This conference will be held on a continuing annual basis sponsored in rotation by the academic institutes of the several midwestern states.

Sports Medicine Congress

A Sports Medicine Congress, one of the most significant conferences of its kind ever scheduled, will be held in conjunction with the Third Pan American Games, scheduled for Chicago August 27–September 7.

The Congress will meet on the Chicago campus of Northwestern University September 1–2, and will feature outstanding experts in the fields of athletic training, care of injuries, diet, cardiovascular effects of sports activity, and many other facets of the sports medicine field.

(continued)

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Paul Dudley White, M.D., world-famed Boston heart specialist who attended President Eisenhower during the latter's illness and convalescence, will be the featured speaker at the first plenary session of the Congress September 1.

All sessions of the Congress will be open to all persons interested in the field of sports medicine. Further information can be obtained from Dr. Van Dellen at Pan American Games, Inc., 310 South Michigan Ave., Chicago 4.

American Rhinologic Society

The American Rhinologic Society will hold its fifth annual meeting in the Belmont Hotel, Chicago, October 10. This will be preceded by a surgical seminar in the Illinois Masonic Hospital, Chicago, October 7–9.

The scientific program at the hotel on Saturday, October 10, will consist of:

"Symposium on Objective Tests for Nasal Function," Panelists, Drs. Juergen Tonndorf, Paul M. Seebohm, and William K. Hamilton, Iowa City; Herman J. Sternstein, Boston; Raymond L. Hilsinger, Cincinnati. Discussion by Drs. Maurice H. Cottle, Chicago, founder of the Society; David Cugell, Chicago, and Henry L. Williams, Rochester, Minn.

"Trans-septal Pituitary Extirpation," Dr. Walter E. Heck, San Francisco.

"Choices of the Rhinologist in Approaching the Tear Sac," Dr. Lester T. Jones, Portland, Ore.

"Surgery of Nasal Malignancies," Dr. John J. Conley, New York.

"Tissue Reactions to Nasal Transplants," Dr. William B. Barry, Kansas City.

"Basic Immunology of Bone Transplants," Dr. James A. Dingwall, Squibb Institute for Medical Research, New Brunswick, N. J.

The first official showing of a new color and sound film, "The Human Nose," will follow the evening dinner.

Physicians and guests are invited. There is no registration fee.

For further information write to Dr. Robert M. Hansen, secretary, 1735 N. Wheeler Avenue, Portland 12, Ore.

Course in Postgraduate Gastroenterology

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Biltmore in Los Angeles, Calif., on September 24, 25, 26, 1959.

The subject matter to be covered in the Course, from a medical as well as surgical viewpoint, will be essentially, the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Institute of Ultrasonics

The American Institute of Ultrasonics in Medicine will hold its Annual Meeting on September 2, at the Leamington Hotel, Minneapolis, Minn. The guest speaker at the luncheon meeting will be Russell Meyers, M.D., Professor of Surgery and Chairman, Division of Neurosurgery, State University of Iowa Hospitals and College of Medicine, who will discuss "The Potentials of Ultrasonics in General Surgery and Surgical Specialties." For any further information contact John H. Aldes, M.D., Secretary, 4833 Fountain Avenue, Los Angeles 29, Calif.

Other Dates to Remember

Aug. 31–Sept. 4—Second World Conference on Medical Education, Chicago, Ill.

Sept. 7–12—13th General Assembly, The World Medical Association, Montreal, Canada.

Sept. 13–17—24th annual Congress of the North American Federation, International College of Surgeons, Chicago, Ill. Further information from: Secretariat, ICS, 1516 Lake Shore Drive, Chicago 10, Ill.

Sept. 14–Nov. 6—Institute of Industrial Medicine, New York University Post-Graduate Medical School, offers two-month course for physicians in occupational medicine. For applications address: Office of the Associate Dean, N. Y. Univ. P–G Medical School, 550 First Avenue, New York 16, N. Y.

Sept. 18–26—Annual Otolaryngologic Assembly, University of Illinois School of Medicine postgraduate course.

Oct. 10–Dec. 1—Fourth "around-the-world" postgraduate refresher clinic tour of the International College of Surgeons. Further information from: Secretariat, ICS, 1516 Lake Shore Drive, Chicago 10, Ill., or to the International Travel Service, Inc., 119 South State Street, Chicago 3, Ill.

Nov. 8–9—Council on Arteriosclerosis of the American Heart Association, Hotel Knickerbocker, Chicago.

Nov. 9–21—Postgraduate course in laryngology and bronchoesophagology, University of Illinois School of Medicine.

May 15–18, 1960—12th biennial International Congress of the International College of Surgeons, Rome, Italy. For information: Secretariat, ICS, 1516 Lake Shore Drive, Chicago 10, Ill.

July 18–22, 1960—Fifth International Medical Conference, sponsored by the National Foundation, London, on the subject of congenital malformations, with some 50 nations expected to participate.

Sept. 28–Oct. 5, 1960—Eighth Congress of Pan-Pacific Surgical Association, Honolulu, Hawaii. Further information and brochures from: Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

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said: Dr. Louis Brooks in a paper published Sept., Oct. issue, Diseases of the Colon and Rectum, Vol. 1, No. 5.

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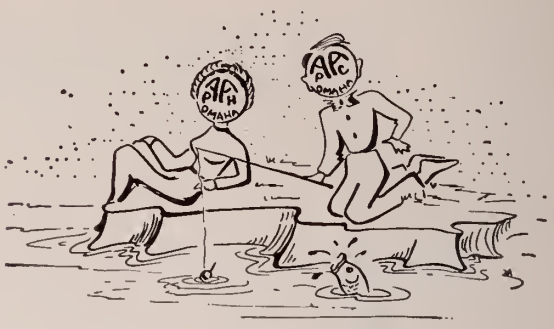

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

Cold Injury, Ground Type. Prepared under the direction of Major General S. B. Hays, The Surgeon General, United States Army. By Colonel Tom F. Whayne, MC, USA (Ret.), Professor of Preventive Medicine, School of Medicine, University of Pennsylvania, Philadelphia, Pa., and Michael E. DeBakey, M.D., Professor of Surgery and Chairman of the Department, Baylor University College of Medicine, Houston, Texas, formerly Colonel, MC, AUS. Medical Department, United States Army, Office of the Surgeon General, Washington, D. C. 1958. 570 pages. Price: $6.25.

The book entitled "Cold Injury, Ground Type" by Col. Tom F. Whayne, M.D., U.S.A. (Ret.) and Michael E. DeBakey, M.D. is a most interesting and intriguing volume. In it are the history and record of cold injury, ground type, as incurred by American Military personnel during World War II. Suffice it to say, if studied in its completeness this type of military injury could be deleted from military medicine in the event of a future war.

Combination of wet and/or cold are the principal factors in cold injury. In addition, predisposing factors such as (a) the type of combat that prevents the infantry man from limiting his exposure to cold, (b) inadequate clothing and foot gear, and (c) failure to instruct new troops in simple preventive cold injury measures.

In addition, the authors go into great detail as to the underlying patho-physiology of cold injury; its epidemiology and its management, including immediate and late treatment. Lastly, certain sound principles are formulated as to the prevention and control of this type of trauma from both a command and medical level.

The total number of cold injury cases for World War II totaled 91,000—nearly 8 divisions of men. A factor in itself that should make the medical profession more aware of the seriousness of an oft-forgotten and misunderstood type of trauma.—JOHN T. PHELAN, M.D.

Communicable Diseases; Transmitted Chiefly Through Respiratory and Alimentary Tracts. Volume IV. Prepared and published under the direction of Major General S. B. Hays, The Surgeon General, United States Army. Office of the Surgeon General, Department of the Army, Washington, D. C. 1958. 544 pages. Price: $5.50.

To quote from the foreword by the Surgeon General, "During World War II the problems of the prevention and control of communicable disease in the Army, and in the populations with which the Army was in contact, were of unprecedented complexity and magnitude. A story of the activities of the Medical Department in dealing with these problems, together with some account of deficiencies and successes, will occupy at least three volumes in the preventive medicine series of the history of the Medical Department in World War II".

To what extent these activities were successful may be inferred from some interesting statistics in the introduction written by Dr. John E. Gordon of the Harvard School of Public Health. Disease as a factor in military operations has often been of tremendous significance; sometimes there have been 12 deaths from disease to 1 battle casualty. However in World War II there was a dramatic reversal of this, since, of all deaths for U.S. troops under arms, only 5% were due to disease—actually less than the number due to *non*-battle injuries (19.7%).

Following an excellent introduction, 21 contributors discuss the problems presented by each of the major respiratory or enteric infectious diseases. Each disease is considered under various headings; there is lack of uniformity in each author's approach, understandable because of the diverse problems posed by the different infections under consideration. This volume furnishes a valuable reference source for the incidence and control measures employed in each theater of operations and the continental U.S.—C. V. SEASTONE, M.D.

NEW BOOKS RECEIVED

Clinical Obstetrics and Gynecology. A quarterly book series. Symposium on Special Diagnostic Aids, edited by C. Paul Hodgkinson, M.D., and Symposium on Abnormal Uterine Bleeding, edited by John I. Brewer, M.D. Paul B. Hoeber, Inc., 49 East 33 St., New York 16, N. Y. September 1958. 852 pages. Subscription price: $18.00/year.

Experimental Pharmacodynamics. By T. Koppanyi and A. G. Karczmar. Second edition. Burgess Publishing Company, 426 South Sixth Street, Minneapolis, 15, Minn. 1955–1958. 258 pages.

The Measurements and Appraisal of Adult Intelligence. By David Wechsler, Chief Psychologist, Bellevue Psychiatric Hospital, Adjunct Professor of Psychology, Graduate School of Arts and Science, New York University College of Medicine. 4th Ed. Williams & Wilkins Co., Baltimore. 1958. 255 pages. Price: $5.00.

Hearing, A Handbook for Laymen. By Norton Canfield, M.D., Associate Clinical Professor of Otolaryngology, Yale University School of Medicine, President of the Audiology Foundation. Doubleday & Company, Inc., Garden City, New York. 1959. 214 pages. Price: $3.50.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR RENT: Four-room physician's suite, fully equipped, including a 100MA x-ray unit, in the business section of the city of Brookfield on the outskirts of Milwaukee. This suite is on the ground floor in a new air-conditioned clinic building. The area is very prosperous with rapidly expanding population and a doctor is badly needed. Very generous terms would be offered and long term financing is available. Address replies to Box 756 in care of the Journal. m11tf

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FOR RENT: Front offices. Best location for general practice. Contact Box 772 in care of the Journal. 4tfn

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WANTED: YOUNG GENERAL PRACTITIONER with interest in general surgery to join group of three GPs in suburban central Wisconsin. Three adjacent hospitals. Generous salary with partnership in reasonable time. Contact Box 794 in care of the Journal. m7–9

FOR SALE: Physician's complete office equipment, large office, reasonable rent, good active general practice grossing 30 to 35 thousand. Step in and start working. Five thousand for equipment (large x-ray machine, lab., two diathermy machines, large safe, surgical instruments, two sterilizers, infra-red lamps, ultra violet, surgical spot lamps, cabinets, examination tables, office furniture, typewriter, adding machine, etc.) SPECIALIZING. Contact Box 757 in care of the Journal. m11tf

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FOR SALE: Fluoroscope—G.E., vertical, complete with tube and transformer, ortho-diagraphic attachments. $400 as is. $600 installed. Contact Box 789 in care of the Journal. g6tf

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FOR SALE: Office equipment, including Hamilton treatment cabinet and instrument cabinet. Astral refrigerator, Ritter motor chair and ENT M.A. outfit, Ritter compressor, flat top examining table, stainless steel instruments, and basins, etc. and other diagnostic instruments. All purchased new, and used 4 years. Address inquiries to: G. W. Brewer, M.D., 5000 Erie Street, Racine, Wisconsin. m6–7

WANTED: Physician to join active Capitol clinic group in Milwaukee. Contact Administrator, Capitol Hospital, 1971 West Capitol Drive, Milwaukee. m6tf

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WANTED: General practitioner to take over thriving, unopposed practice. New home, office, and equipment for rent. Nothing to buy. Specializing. Contact O. M. Schneider, M.D., Blair, Wisconsin. m6–7

FOR SALE: 30 MA x-ray unit, portable, in excellent condition, $200. Phone or write: R. E. Hunter, M.D., Argyle, Wisconsin, KImball 3–5751. m7–8

OPPORTUNITY for medical specialist, or general practitioner, at Racine Medical Center. Located in the heart of downtown Racine across from the recently completed First National Bank Building, completely air conditioned and constructed with the medical profession in mind. We now have a first and second floor suite available which can be arranged to suit your needs. Rent reasonable and lease to suit your requirements. There are suites now occupied by a pedontist, a periodontologist, a D.D.S., a chiropodist, and a dermatologist. Please call or stop by for an inspection of the building to compare what there is available before making a decision on rental space. This is an opportunity that a medical man with a progressive outlook cannot afford to miss inquiring into before deciding on his permanent location. Contact Eugene R. Gottfredsen, Ritt Realty Company, 2733 Washington Avenue, Racine, Wisconsin, Telephone ME 7–1277. 7–10

RENT OR BUY: General practitioner leaving community with drawing population of 4,000 near Madison. General practice office and equipment with trained medical assistant available. Immediate possession. Contact Box 766 in care of the Journal. m2tfn

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WANTED: GENERAL PRACTITIONER for community in northern Wisconsin recreation area. Practice established 25 years. Physician retiring. No physician within 20 miles. Large home and office combined, for sale or rent, with or without office equipment. Terms arranged. Write Ogema Lions Club, Ogema, Wisconsin. m5-8

WANTED: Physician with Board Certification or background in internal medicine and interest in dynamic psychiatry and rehabilitation, to serve as full-time Chief of Geriatric and Infirmary Service including participation in residency, medical student, and other training programs at Mendota State Hospital; to develop programming utilizing Nursing, Social Service, Occupational Therapy and Recreational Therapy personnel and volunteers in team fashion toward treatment and rehabilitation goals; and to begin developing plans for a new infirmary and rehabilitation-type building on the hospital grounds. Starting salary up to $11,800 depending upon qualifications. Also other State Civil Service benefits. Address inquiries, with summary of qualifications, to Walter J. Urben, M.D., Superintendent, Mendota State Hospital, 301 Troy Drive, Madison 4, Wisconsin. g2tfn

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WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service, salary depends upon previous experience and training. Housing available on grounds. Contact Dr. W. J. Urben, Superintendent, Madison 4, Wisconsin. 1tfn

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WANTED: Associate in active general practice with eventual partnership. City of 12,000 in west central Wisconsin. Ideal hospital facilities. Unlimited recreational facilities, good schools, and living conditions. Contact Box 792 in care of the Journal. m7–9

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(continued)

THE
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LETTERS OF INTEREST

RESUME OF ACTIVITIES OF MARQUETTE SAMA AND STUDENT MEDICAL COUNCIL—JUNE 1, 1959

To SMS:

Here is the final SAMA report I had promised you recently. I hope it may be of interest.

Again may I thank the State Medical Society for all the aid—financial and advisory—that you have given us in the past year. Your continued support is indeed important to our success, and I hope that our activities merit further help, counsel and interest.

* * *

This report will attempt to describe the activities that have transpired since the writing of the first report of December, 1958.

On January 27, 1959 the first meeting of the newly proposed SAMA Auxiliary was held at the Medical School. Dr. John S. Hirschboeck, Dean, spoke to the wives about their own careers in medicine. This was followed by a program on natural childbirth.

Lourdes Hall of St. Joseph's Hospital was the scene for the second SAMA Social–Educational meeting on February 20th; the guest was Mr. Oliver Field, Director of the AMA Bureau of Investigation, who discussed "Quackery in Medicine." And on March 27th, William Lamers, Ph.D., Assistant Superintendent of the Milwaukee Public Schools presented his theme: "A Good Man Skilled in the Art of Healing." Both programs were received with great interest.

Marquette welcomed the annual Spring meeting of SAMA's Region 5 on Sunday, March 22nd at the Medical Library. Representatives from Wisconsin, Minnesota, Missouri, Northwestern, University of Chicago and Marquette attended. Lakeside Laboratories hosted the noon luncheon at the Stratford Hotel.

Elections for the 1959–60 officers of the SAMA–Student Council were held on April 8th. The victors were: John McKenna, President; Gene Izuno, Vice-president; William Pier, Secretary; and Gene Sinclair, Treasurer. The first President of the new Auxiliary is Mrs. Robert (Barbara) Feldt.

About 500 high school and premedical students attended the annual Career Guidance Day at the Medical School on April 18. Cochairmen Robert Toohill and Brian Coffey, aided by Mike Belson, Jim Freel, Dan Thearle, Stan Sherry, Chuck Bergschneider and Jack Lannon presented probably the finest program ever. Movies, exhibits, tours and discussions highlighted the day. So successful is the guidance program that it was featured in an article in the May issue of *The New Physician*, national SAMA journal.

SAMA held its national convention in Chicago April 29–May 3. Marquette was represented by Delegate Richard Marohn who served as the Credentials Committee and Alternate John McKenna. Complete details of the House of Delegates' transactions and the scientific sessions are available in *The New Physician*. Noteworthy though, were the chartering of Marquette's Auxiliary Chapter and the fact that two of the eight student scientific exhibits were from Marquette: John Mullooly—"Chromatographic and Autoradiographic Analysis of Rat Tissues after Injection with I^{131}—labeled Thyroxine," and Clara Hussey, John Harris and Kenneth Peters—"Effect of Injected Thrombin on the Coagulation Factors." The latter exhibit won the second prize of $250. As usual the convention was most valuable for its interchange of idea on student problems and topics. The delegates' expenses were financed by a $100 grant from the State Medical Society of Wisconsin.

This year's officers wish to express their thanks to the faculty, students and friends who aided the year's activities, with the hope that something constructive was done for the school and profession.

RICHARD C. MAROHN
Student American Medical Association
Marquette University School of Medicine
561 North Fifteenth Street
Milwaukee 3, Wisconsin

A New Feature Starts This Issue!

State Medical Society officers and staff and the editors of the *Wisconsin Medical Journal* frequently receive letters of inquiry or information on all types of matters affecting the profession and public health. Many of these are of interest to every physician in the state. To help convey these messages, the *Journal* has added a new feature, "Letters of Interest", which will appear regularly in the front section of the *Journal*. Letters received, and in some instances the replies, by physicians who feel that they might be of interest to others in the state will be welcome.

TANGIBLE SUPPORT FOR PROFESSIONAL EDUCATION

To SMS:

Expenditures totaling $1,010,486 to assist the educational programs of the medical and allied professions were recommended by the Advisory Committees of the National Foundation at their semiannual meeting in April. The amount is in addition to the nearly 31 million dollars that has been authorized for professional education since 1938.

New for this year was the recommendation that $65,000 be authorized to provide fellowships for physicians and surgeons to study in the clinical fields of rheumatology and management of congenital malformations of the central nervous system. Fellowships will be offered to residents or to more experienced physicians who desire this type of opportunity.

The committee recommended continuation of current support to a number of medical schools who have been conducting pilot studies in teaching the concept and basic techniques of rehabilitation to undergraduate and graduate medical students. An extension to Marquette University School of Medicine, Milwaukee, for a three-year grant of $85,688 was recommended for approval.

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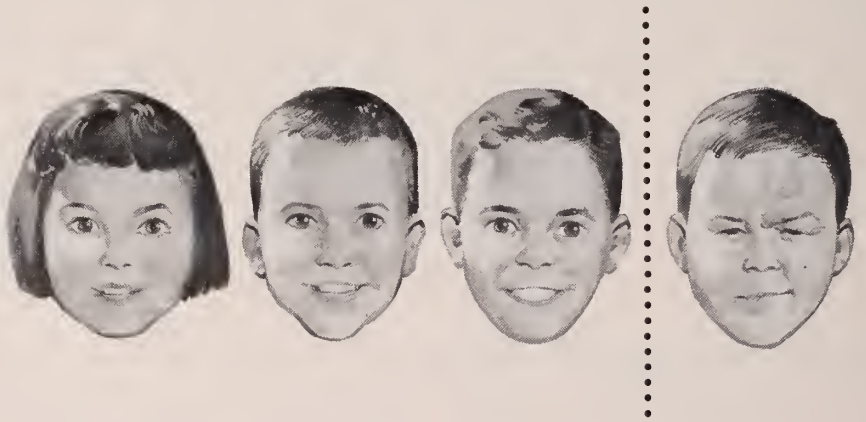

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County Society Proceedings

ASHLAND–BAYFIELD–IRON

Thirteen members and wives of Ashland, Bayfield and Iron County Medical Society met for a dinner meeting June 10 at the Platter in Ashland. The program included a medico-legal talk by Mr. Barney Barstow, an attorney from Superior, who stressed (1) causes for malpractice suits, (2) reasons why malpractice suits are started, and (3) what can the doctor do to protect against malpractice suits. The subject brought out a number of questions which were asked during a discussion period. Members passed a motion to endorse and welcome the teaching clinic scheduled for Ashland on Wednesday, October 14.

GREEN LAKE–WAUSHARA

"Neurological Diagnosis as Related to General Practice" was the subject chosen by *Dr. Peter L. Eichmann* of the University of Wisconsin when he addressed the members of the Green Lake–Waushara County Medical Society on May 13. The members and their wives met at White Lake for the dinner meeting. In tribute for his 50 years in the practice of medicine, *Dr. A. J. Wiesender*, Berlin, was presented with a gift from the group.

MANITOWOC

The Manitowoc County Medical Society recently elected the following slate of officers for the 1959–1960 term:

President—*R. J. Banker*, M.D.,
Vice-President—*W. E. Acheson*, M.D.
Secretary–Treasurer—*D. A. Kuljis*, M.D.
Delegate—*W. E. Acheson*, M.D.
Alternate Delegate—*N. A. Bonner*, M.D.

POLK

Dr. Harold A. Rief of Minneapolis, Minnesota, discussed "Urology and Urography" at the May 21 meeting of the Polk County Medical Society held at Paradise Lodge in Balsam Lake. A round table discussion followed his lecture. Fifteen members were present.

On June 18 the Polk County Medical Society and Woman's Auxiliary met for dinner at Paradise Lodge as guests of *Dr.* and Mrs. *W. H. Byrne* of Amery. During the evening Dr. Ian Brown of St. Paul, Minnesota, talked on the progress made in the establishment of a private medical school in St. Paul.

Actions taken during the business session were the approval of the Polk County Public Welfare Department fee schedule and approval of the immunization schedule with the Polk County Public Health nurse for the coming year.

RICHLAND

The Richland County Medical Society met May 7 in the Richland Hospital Library. Guest speaker for the occasion was Mr. Frank T. Creeron, Director of Welfare in Richland county, who talked on "Welfare Problems."

SAUK

Seventeen members of the Sauk County Medical Society met May 12 at Uphoff's Rotunda in Lake Delton to hear *Dr. F. J. Davis*, Madison, speak on office ophthalmology.

During the business meeting *Dr. C. R. Pearson*, Delegate, reported on the 1959 sessions of the House of Delegates. *Dr. Milton Trautmann* also told of the Charitable, Educational and Scientific Foundation session.

WOOD

Wilbern's in Wisconsin Rapids was the site of the May 21 meeting of the Wood County Medical Society. Two of their members, *Drs. D. A. Emanuel* and *G. G. Griese*, both of Marshfield, lectured on "Techniques in the Diagnosis of Cardiac Lesions."

Physicians whose names appear in italics are members of the Society.

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Milwaukee Gynecological Society

At the annual business meeting of the Milwaukee Gynecological Society, held on May 25, the following officers were elected:

President—*B. E. Urdan, M.D.*

Vice-President—*Alice D. Watts, M.D.*

Dr. John Thoma had been elected the previous year to serve a two-year term as Secretary–Treasurer.

Milwaukee Neuro-Psychiatric Society

On May 20 the Milwaukee Neuro–Psychiatric Society held its annual meeting at the University Club of Milwaukee. Providing the lecture at the scientific session was Dr. I Arthur Mirsky, professor and chairman of the Department of Clinical Science at the University of Pittsburgh School of Medicine. Doctor Mirsky spoke on "Physiologic, Psychologic, and Social Determinants in the Etiology of Duodenal Ulcer".

Physicians whose names appear in italics are members of the Society.

Wisconsin Society of Obstetrics and Gynecology

A business meeting was held by the Wisconsin Society of Obstetrics and Gynecology in Milwaukee on May 7. *Dr. R. F. Lewis*, Marshfield, was elected president for the ensuing year. Also chosen for office were *Dr. David Werner*, Milwaukee, first vice-president, and *Dr. John Boersma*, Green Bay, secretary-treasurer.

Central Chapter of the Wisconsin Academy of General Practice

The newly organized Central Chapter of the Wisconsin Academy of General Practice was presented a charter on July 1 at a medical conference held in Port Edwards. Speakers from the University of Minnesota Medical School comprised the program.

Counties included in the chapter are Portage, Wood, Waushara and Waupaca. Officers of the new group are:

President—*Dr. W. A. Gramowski*, Stevens Point
Vice-President—*Dr. L. R. Pfeiffer*, Nekoosa
Secretary-treasurer—*Dr. George Handy*, Wisconsin Rapids

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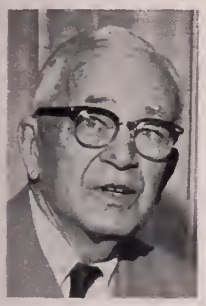
News of Wisconsin Physicians

Doctor Arveson Retires

A Frederic physician for 50 years, *Dr. R. G. Arveson,* retired from active practice in May. After his many years in the profession, he plans to remain in Frederic.



Dr. Arveson

Doctor Arveson this year stepped down from the chairmanship of the Council of the State Medical Society after serving in that capacity the past 11 years. Last October his community held an open house in tribute of his many services to it.

Doctor Arveson's medical career began with graduation in 1906 from the Wisconsin College of Physicians and Surgeons, now Marquette University, and a year of internship at St. Joseph's Hospital, Milwaukee. He first located in Hiles as physician and surgeon for a lumber company. Doctor Arveson located in Frederic in September of 1909. He and his partner, Dr. J. A. Diamond, founded the Frederic Hospital in 1916, and in 1945 turned it over to the community.

Medical Conference Held in Marshfield

In May members of the staffs of the Gundersen and Marshfield Clinics attended the first in a series of interclinical professional seminars scheduled for these two groups. The session was held in the Marshfield Clinic Library.

Papers were presented by three La Crosse clinicians, *Dr. Sigurd Gundersen, Jr.,* on pancreatic resection for cancer, *Dr. George B. Murphy* on surgical repair of bladder stress incontinence, and *Dr. Rolv Slungaard* on hypo-plastic kidney and nephritis. *Dr. B. R. Lawton,* Marshfield, led the discussion.

The next meeting will be held at La Crosse in the fall with the Marshfield physicians presiding at the scientific session.

Doctor Petersik to Open Private Practice

Effective October 1, *Dr. John T. Petersik* will leave his post as superintendent of Winnebago State Hospital to open a private practice in Oshkosh. He first came to that hospital in 1940, accepting the superintendent's position in 1952.

Physicians whose names appear in italics are members of the Society.

Name Medical Directors of Rest Home

Two Washburn physicians, Drs. R. G. Carter and *Harold Guzzo,* were chosen as medical directors of the Bayfield County Rest Home. The institution's trustees have designated that the physicians will alternate the responsibilities at the home every six months.

Specialist Added to Skemp Clinic

Dr. David Corser joined the Skemp Clinic, La Crosse, in June. A specialist in pediatrics, he graduated from the Washington University Medical School, interned at Minneapolis General Hospital, and took a residency at the University of Minnesota Hospital. Prior to coming to La Crosse, Doctor Corser spent two years with the U. S. Army as head of the children's department at the Ft. Riley Army Hospital, Kansas.

Doctor Hildebrand Talks

"Our Debt to the Women in White" was the subject of a speech delivered by *Dr. W. B. Hildebrand,* Menasha, at the annual meeting of the Milwaukee County Red Cross chapter on June 18. As this year marks the 50th anniversary of the American Red Cross nursing service, the program was in tribute to their work.

Doctor McCarthy Leaves Wisconsin

Dr. M. J. McCarthy left Hillsboro June 17 to become associated with a clinic and to open a private practice in surgery in Honolulu, Hawaii. He first came to Hillsboro in 1955, leaving after two years to practice for a short time in his native city of Washington, D. C.

Markesan Doctor Joins Elkhorn Clinic

Dr. Milton F. Stuessy has left Markesan to associate with Drs. *E. D. Sorenson, J. A. Rawlins* and *K. C. Bill* in the practice of medicine at the Elkhorn Clinic, Elkhorn. Prior to locating in Markesan a year ago, Doctor Stuessy graduated from the University of Wisconsin Medical School, interned at Memorial Hospital, South Bend, Indiana, practiced five months at Hollandale, and served with the U. S. Army for two years at Fort Benning, Georgia.

Taking Postgraduate Training

On July 15 *Dr. Carl W. Schmidt* began residency training in anesthesiology at the University of Wisconsin. Doctor Schmidt came to Waterloo to practice in 1949, and in 1955 was joined by *Dr. J. Ralph Fowler* as an associate.

(continued)

Surprise for Doctor Heidner

The State Medical Society Council honored one of its long-time members at a surprise dinner party in May just prior to the opening session of the 1959 annual convention. The honored guest was *Dr. A. H. Heidner*, of West Bend, who had served on the Council since 1929 with the exception of the 1951–52 term in which he served as president of the SMS.

Photo courtesy WEST BEND NEWS

Dr. A. H. Heidner, honored guest at a surprise dinner, is shown above (center) looking over the guest book with Dr. J. C. Fox, Chairman of the Council, and Dr. W. B. Hildebrand, President of the State Medical Society.

The surprise event was held at the West Bend Aluminum Co. cafeteria in West Bend. Councilors, Doctor Heidner's family and close relatives and friends were in attendance.

Dr. J. C. Fox, La Crosse, chairman of the Council, gave the main address and paid tribute to "Doctor Heidner's contributions to his community, to his professional colleagues and to the public health of Wisconsin."

Presented to Doctor Heidner was a special swivel chair, carrying memories. A small gold plate on the chair carries the inscription: "The Council Chair of Albion H. Heidner, M.D.—West Bend—Fifth District Councilor of the State Medical Society of Wisconsin—1929–1934, 1936–1958.

Retires from Health Post

Dr. G. B. Merline, De Pere, retired June 30 as De Pere health officer. Succeeding Doctor Merline is *Dr. W. F. Elders*. Doctor Merline was appointed to the post in 1947. During his tenure De Pere received recognition as one of the first cities in Wisconsin to conduct a community-wide adult diabetic test.

Doctor Cary Honored by Legion

Dr. E. C. Cary, Reedsville physician and surgeon, was honored July 13 when he was awarded a life membership in the American Legion during a testimonial dinner event.

Doctor Cary was instrumental in organizing the Reedsville American Legion Post No. 199 in December, 1919. He was the first commander and later served four consecutive terms in that office.

Dr. Sarah Rosekrans Speaker

The Wisconsin State Medical Assistants Society chose *Dr. Sarah Rosekrans* of Neillsville as their banquet speaker during the fifth annual meeting. The group met in Eau Claire, June 5–7.

Doctor Halgrimson Relocates in State

During June *Dr. K. W. Halgrimson* moved from Mondovi where he had practiced for the past year. He now has offices in the Whitehall Clinic, Whitehall, and is a staff member of the Community Hospital.

Wausau Physician Receives Appointment

Dr. D. J. Freeman of Wausau was named to a three-year term as director of the Wisconsin Heart Association. The election took place at the association's annual meeting held in Milwaukee, June 13.

Doctor Joins New London Physician

A graduate of the University of Nebraska Medical School, Dr. J. W. Weber, is now associated with *Dr. H. C. Schmallenberg*, who has been established in New London nearly 25 years.

The two physicians will have offices located in a clinic consisting of 15 examination rooms, special treatment rooms and laboratories.

Elected to Cancer Society Board

Dr. Lee L. Bathke, Sheboygan dentist, has been elected to the state board of the American Cancer Society, Wisconsin Division. Doctor Bathke's keen interest in the cancer control program of the Sheboygan County Unit of the Society was climaxed last fall by his election as president of the Unit. *Dr. P. B. Blanchard*, Cedarburg physician, is also a member of the board.

California Doctor New In Platteville

A general practitioner, Mr. John C. Schmitt, is now affiliated with *Drs. C. L. Steidinger* and *M. L. McCumber* of Platteville. A native of Illinois, Doctor Schmitt graduated from the University of Illinois College of Medicine in 1955. Following a rotating internship at San Bernardino Charity Hospital in California, he entered the U. S. Navy, serving duty in Australia, the Far East, and San Diego, California. Upon release, Doctor Schmitt practiced for six months in California and then took a one-year internal medicine residency at San Bernardino County Charity Hospital before coming to Wisconsin.

(continued)

Doctor Frantz Opens Office

Dr. R. G. Frantz has begun private practice in Waukesha after completing four years of general surgery residency in Milwaukee. Doctor Frantz served in the U. S. Navy during World War II and graduated from the University of Wisconsin Medical School in 1954.

Certifications for Wisconsin Physicians

The following Wisconsin physicians were certified by the American Board of Obstetrics and Gynecology on May 16, 1959, when final certifications in this specialty were made:

Dr. Gordon F. Burgess, Milwaukee
Dr. Rowland W. Leiby, Jr., La Crosse
Dr. Gerald L. Mullaney, Milwaukee
Dr. Alwin E. Schultz, Madison
Dr. Raymond E. Whitsitt, Madison

Rotarians Hear Medical Costs Panel

The increased costs of medical care in recent years was the subject of a panel discussion at the June 1 meeting of the Shawano Rotary Club. *Dr. Hector Marsh* moderated the panel and *Dr. Roger Cantwell* represented the physician member of the panel. The members talked over the different phases of the problem, explaining why the steady increase has occurred.

Doctor Sargeant Moves

On June 15 *Dr. Charles Sargeant* opened offices in Bailey's Harbor. Following his medical training, Doctor Sargeant began practice in Chilton where he has been for the past three years. His home was in Manitowoc.

Doctor Schoene Resigns Hospital Post

The resignation of *Dr. F. C. Schoene* as chief pathologist at the Waukesha Memorial Hospital became effective August 1. Doctor Schoene, who had been affiliated with the hospital since 1951, is moving with his family to Mesa, Arizona.

Golf Winners of Annual Tournament

Dr. Durward Baker, Wauwatosa, shot a 75 to win first low gross in the annual golf tournament held May 4 at the North Hills Country Club in Milwaukee preceding the SMS annual convention.

Second low gross was won by *Dr. C. L. Budny*, Milwaukee, with a 77. *Dr. J. P. Fetherston, Sr.*, Milwaukee, won the first low net prize with a 98–30–68. *Dr. S. E. Zawodny*, Milwaukee, with a 78–9–69, and *Dr. J. N. Dhuey*, also of Milwaukee, with a 84–15–69 tied for second low net.

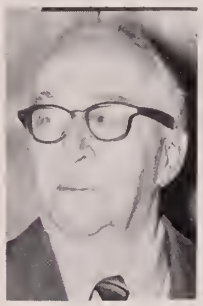
Dr. Paul Purtell, another Milwaukeean, shot an 84 to win the senior low gross traveling trophy.

Other prizes went to *Drs. E. S. Brusky*, Green Bay, for longest drive on No. 9; *John T. Garren*, Kenosha, longest drive on No. 18; *David U. Cookson*, Madison, closest to the pin on No. 3; and *W. C. Harris*, Racine, closest to the pin on No. 16.

Blind bogey prizes were won by the following physicians: C. L. Budny, *W. J. Buggy*, Milwaukee, *H. F. Ibach*, Milwaukee, *Marvin Sattler*, Milwaukee, and *R. A. Wood*, Sheboygan, (77); *R. C. Pauly*, Sheboygan, and *F. J. Rankin*, Appleton, (73); *J. M. Bell*, Marinette, *F. J. Davis*, Madison, *N. C. Erdmann*, Manitowoc, *J. H. Holman*, Racine, *W. A. Nielsen*, West Bend, *R. A. Straughn*, Madison, and *A. C. Tompsett*, Sheboygan, (78); Durward Baker, *J. J. Barrock*, Milwaukee, *H. J. Belson*, Manitowoc, *W. J. Frawley*, Appleton, *L. E. Fazen, Jr.*, Racine, J. T. Garren, W. C. Harris, *T. F. Jennings*, Milwaukee, *D. M. Mehigan*, Milwaukee, *D. L. Morris*, West Salem, *L. F. Thurwachter, Jr.*, Milwaukee, *W. H. Williamson*, Racine, *D. L. Wood*, Wauwatosa, and Arthur Zerker (80).

Still Practicing After 55 Years

The dean of Hartford's physicians, *Dr. J. Greg Hoffmann*, is still carrying on a full schedule in his practice after 55 years. In May 14 physicians and surgeons from Hartford, West Bend, Slinger, Allenton, Mayville, Campbellsport and Milwaukee honored him for his many years of service in the profession.


Dr. Hoffmann

Doctor Hoffmann is a 1904 graduate of the Wisconsin College of Physicians and Surgeons, now known as Marquette University, Milwaukee. He practiced at Prairie du Chien one year before starting his practice at Hartford. He has been Hartford's health commissioner for the past 40 years.

Photo courtesy HARTFORD TIMES PRESS

New Officers of WHA

Seven Wisconsin physicians are among the new officers, board of directors and delegates of the Wisconsin Heart Association elected at its annual meeting June 13 in Milwaukee. *Dr. J. C. Peterson*, Milwaukee, was named president-elect. He is professor of pediatrics, Marquette University School of Medicine. New Board members elected for three-year terms include: *Dr. John H. Huston*, acting director, cardiovascular research section, Marquette University School of Medicine, Milwaukee; *Dr. W. A. Himmelsbach*, La Crosse, also a member of the La Crosse District Heart Committee; and *Dr. D. Joseph Freeman*, Wausau.

Dr. Ross C. Kory, associate professor of medicine, Veterans Administration Hospital, Wood, was elected for a one-year term to fill a vacancy. Elected as voting delegates to the American Heart Association for two-year terms are: *Dr. Robin N. Allin* and *Dr. Charles W. Crumpton*, both of Madison.

(continued)

THIRD AND TWELFTH DISTRICTS

Doctor Tormey, Jr. Moves

In June *Dr. A. R. Tormey, Jr.*, moved to Temple, Texas, to become associated with the Scott and White Clinic in the department of urology. The physician had been practicing in Madison for the past two and a half years.

Arthritis Group Met in July

Dr. A. W. Bryan, Madison, president of the newly established Dane County Arthritis Affiliate, in the picture below, discusses the group's progress with Robert H. Rolfs, president of the Wisconsin Chapter of the Arthritis and Rheumatism Foundation and board member Mrs. Donald D. Hickman at the Chapter's July annual meeting.

Mrs. D. D. Hickman, R. H. Rolfs, and Dr. A. W. Bryan

Wisconsin arthritics are helped through the Chapter's program of research, rehabilitation and public education. The Dane County Affiliate was formed in March to enable the Wisconsin Chapter to serve a greater number of arthritis sufferers in a larger area. The affiliate is currently conducting a campaign to raise funds to underwrite the expenses of its program of research, rehabilitation and public education.

Neurologists Hear Two UW Doctors

A paper entitled "Cranial Deficits Developing at Fracture Sites in Children" was given by *Drs. T. C. Erickson* and *R. A. Lende* at the June 13–17 meetings of the American Neurological Association. Doctor Erickson is professor of surgery at the University of Wisconsin, while the other physician is a resident in that department.

Cudahy Hospital Appoints Pathologist

Dr. Rocco Latorraca has accepted the position of pathologist at Trinity Memorial Hospital, Cudahy. He succeeds the late Dr. J. J. Kurtin.

A graduate of the New York College of Medicine, Doctor Latorraca served his residency at Tufts University–New England Medical Center in Boston. He worked as a pathologist at the Mount Auburn Hospital, Cambridge, Massachusetts, before coming to Milwaukee in July of 1958 when he joined the staff at Milwaukee County Hospital. He became associated with Dr. J. M. Lubitz, pathologist at St. Francis Hospital, last May. Doctor Latorraca is continuing his teaching program at Marquette University in addition to his duties at Trinity and St. Francis Hospitals.

Doctor Jackson Moderates Panel

A Madison surgeon, *Dr. Arnold S. Jackson*, moderated a panel on the treatment of thyroid diseases at a meeting of the New York surgical section of the International College of Surgeons. The physicians met at Kiamesha Lake, New York, May 28–31.

Doctor Peckham Busy in May

Professor and chairman of gynecology and obstetrics at the University of Wisconsin Medical School, *Dr. Ben Peckham*, spent eight days in Chicago as associate examiner at the sessions of the American Board of Obstetrics and Gynecology. Following that he traveled to Hot Springs to present a paper before the American Gynecology Society.

U of W Medical School Association Meets

The Loraine Hotel in Madison was the site of the annual meeting of the University of Wisconsin Medical Alumni Association when more than 200 physicians and guests gathered in May. During the meeting *Dr. A. A. Quisling*, Madison, assumed the post of president of the association, while *Dr. M. J. Lustok*, Milwaukee, was named president-elect. *Dr. Robert Parkin*, assistant to the dean at the University Medical School, was reelected as secretary-treasurer.

Examiners at Hayward Heart Clinic

On June 3 the Wisconsin Heart Association and Sawyer County Medical Society were co-sponsors of a rheumatic fever and congenital heart disease clinic at the Hayward General Hospital. A Madison internist and past president of the Heart Association, *Dr. Robin N. Allin*, and *Dr. Horace K. Tenney, III*, a Madison pediatrician, saw 25 patients under 20 years of age who had been referred to the clinic by their physicians.

Maternal Deaths Discussed at Madison

Madison physicians and hospital personnel attended a program on the principal causes of maternal deaths on June 23. *Drs. William Kreul*, Racine; *G. S. Kilkenny* and *F. J. Hofmeister*, both of Marquette University; and *T. A. Leonard* and *William Kiekhofer*, both of the University of Wisconsin, spoke at the session which was held in the offices of the State Medical Society.

(continued)

Receive Fellowships

Drs. Clifford H. Kalb, Milwaukee, and John Rankin, Madison, were among the 210 physicians who received Fellowship certificates June 4 at the Convocation during the 25th Annual Meeting of the American College of Chest Physicians. The meeting was held at Atlantic City, N. J., June 3–7. More than 1,800 physicians and guests attended the meeting.

Doctor Shutkin Receives Appointment

Dr. Michael W. Shutkin, associate professor of medicine, Marquette University School of Medicine, Milwaukee, has been appointed Chief of the Section of Gastroenterology at Milwaukee County General Hospital.

Doctor Schwade Lectures

Dr. Edward D. Schwade, Milwaukee, lectured on epilepsy at the summer session of the curriculum at St. Coletta's School in Jefferson on July 15.

Doctor Garner on AMA Program

Dr. Lawrence L. Garner, Milwaukee, presented a paper before the section on Ophthalmology of the American Medical Association at the Atlantic City meeting on June 11. The title was, "Effect of Levorotary Epinephrine 2 Per Cent on the Intraocular Pressure of the Glaucomatous Eye." The presentation was discussed by Dr. Willis S. Knighton of New York and Dr. Hans Goldmann of Berne, Switzerland. Co-authors were Dr. William W. Johnstone of the University of Illinois Eye and Ear Infirmary, Dr. Elmer J. Ballintine of Western Reserve University School of Medicine and Dr. M. Ichael E. Carroll of Chicago. At the exhibit hall the above co-authors presented an exhibit entitled, "Graphic Demonstration of the Medical Control of Open-Angle Glaucoma."

Doctor Knight Transfers Practice

Dr. Curtis C. Knight, who has been practicing in Verona for the past year, is transferring his practice to Dr. Victor W. Smith, Madison, some time in September. Doctor Knight will spend two years duty with the U. S. Navy and will report for active duty to the Great Lakes Naval Hospital on September 14.

Doctor Smith received his doctor of medicine degree in 1954 from the University of Chicago. He served his internship at the Tripler Army Hospital in Honolulu, Hawaii, 1955–1957. He has had one year of psychiatric residency at the University of Wisconsin, 1957–1958, and one year of surgical residency at Methodist Hospital, Madison.

24th Annual Meeting

MISSISSIPPI VALLEY MEDICAL SOCIETY

ST. LOUIS, MO.
SEPT. 29—OCT. 3

This meeting at Hotel Chase will feature 34 clinical speakers and 40 industrial and scientific exhibits. An innovation this year will be the clinics at the teaching hospitals of St. Louis University and Washington University the first day. Dr. Harvey Flack of London, England, Editor of the *Family Doctor,* the British counterpart of *Today's Health,* will be the principal speaker at the banquet on September 30. Registration for the entire meeting is free, if done on the first day. Nonmembers will pay a $5.00 registration fee for subsequent registration.

16th Annual Meeting

AMERICAN MEDICAL WRITERS' ASSOCIATION

ST. LOUIS, MO.
OCTOBER 2–3

Under the presidency of Dr. Morris Fishbein, formerly editor of the J.A.M.A., this meeting will be held October 2 and 3 at Hotel Chase. This will feature 16 speakers on a variety of subjects pertaining to medical communications on October 2, and will also feature 21 speakers at a Conference on Medical Writing the morning of October 3. Registration will be the same as above.

* * *

All ethical physicians are cordially invited and urged to attend both of these meetings. Programs of either or both meetings may be obtained from Harold Swanberg, M.D., Secretary, M.V.M.S. and A.M.W.A., 209–224 W.C.U. Building, Quincy, Illinois.

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What's New at the Medical Schools

Doctor Haessler Retires

Marquette University School of Medicine's first full-time professor in the clinical departments, Dr. F. Herbert Haessler, retired July 1, 1959. Doctor Haessler has been Professor and Chairman of the Department of Ophthalmology since January 15, 1949, when an anonymous benefactor established the first full-time chair of ophthalmology at Marquette.

Doctor Haessler

The benefactor asked that the professorship be established in memory of the late Dr. John L. Yates, Milwaukee surgeon, and his sister, Mrs. Carol M. Allis. Doctor Haessler devoted his time to the management of the eye clinic and dispensary in the medical school, to teaching medical students, and to the development of a training program for physicians interested in a career in ophthalmology.

Doctor Haessler, who is 69, was born in Milwaukee. He received his B.A. degree from the University of Wisconsin in 1913 and his M.D. from Johns Hopkins University in 1916. He interned at Henry Ford Hospital in Detroit and at Children's Memorial Hospital in Chicago. In 1917 he became an Instructor in Pathology at the University of Louisville, and from 1918–20 he was a Research Associate at the Rockefeller Institute in New York City. He also did postgraduate work in ophthalmology at the Wills Eye Hospital in Philadelphia. In 1922 he established practice in Milwaukee. In 1925 he was certified by the American Board of Ophthalmology.

Since 1944 Doctor Haessler has been the abstract editor of the *American Journal of Ophthalmology*, a position he will continue. In 1953 he published two books, "Primer of Ophthalmology" and "Ophthalmologic Diagnosis." Among his many scientific papers is one published with his wife, also a physician, on corneal tuberculosis where the slit lamp was used for the first time in experimental work.

Doctor Krehl Appointed

Dr. Willard Arthur Krehl, an Associate Professor of Biochemistry at Yale University, has accepted a position at Marquette University School of Medicine as an Associate Professor of Medicine. The appointment, effective July 1, was announced by Dr. William W. Engstrom, the Francis D. Murphy Professor and Chairman of the Department of Medicine.

Doctor Krehl will be a full-time member of the faculty in the Department of Medicine. He was brought to Marquette through an endowment received by the Department of Medicine from an anonymous Milwaukee industrialist. Doctor Krehl will be concerned with the teaching of medical students, interns, and residents at Milwaukee County Hospital and will have his office located at the hospital.

Doctor Krehl, 45, received his A.B. degree in Chemistry in 1935 from Cornell College, Mt. Vernon, Iowa, and his M.S. degree in Biochemistry in 1943 from the University of Wisconsin. His Ph.D. work was completed at the University of Wisconsin in 1945 under the direction of Dr. C. A. Elvehjem. In 1957 he received his M.D. from Yale University.

His academic appointments include a research assistantship at the University of Wisconsin from 1941–45 and a post-doctoral fellowship at Wisconsin from 1945–46. From 1946–58 he was on the faculty of Yale University, first as an Assistant Professor of Nutrition Chemistry and from 1951 on as an Associate Professor of Nutrition Chemistry. After obtaining his M.D. from Yale, he interned and was a resident in medicine at Grace–New Haven Community Hospital.

Doctor Krehl's research work is largely in the field of the biochemical relationship to clinical medicine, particularly in the field of degenerative disorders such as kidney diseases and diabetes.

UW Postgraduate Courses—1959–60

Announcement is made of the eight postgraduate courses to be given at the University Medical School for the coming academic year. The courses are to be given in the new air-conditioned Wisconsin Center Building and present plans are for two guest speakers to participate in each course, in addition to regular faculty members.

A specific program for each course will be announced when arrangements have been completed. All requests for information should be sent to Dr. Robert C. Parkin, Coordinator of Postgraduate Medical Education, 418 N. Randall Ave., Madison, Wis.

General Practice—1959: October 1–3, inclusive. Dr. Robert C. Parkin, Coordinator of Postgraduate Education.

Allergy for the General Practitioner: October 22–24, 1959, inclusive. Dr. Seymour Crepea, Department of Medicine (Allergy Clinic).

Laboratory Diagnosis Problems: Date to be announced. Dr. Frank Larson, Director of Hospital Laboratories and Clinical Pathology Program.

(continued)

MEDICAL SCHOOLS (continued)

Treatment of Fractures in General Practice: Date to be announced. Dr. Herman Wirka, Professor of Surgery.

Therapeutics: February 18, 1960. Dr. Frederick Shideman, Chairman, Department of Pharmacology and Toxicology.

Neurological Problems: March 10–12, 1960, inclusive. Dr. Francis Forster, Chairman, Department of Neurology.

Endocrinology in Pediatrics: April 7–9, 1960, inclusive. Dr. Nathan Smith, Chairman, Department of Pediatrics.

Health Aspects of Air Pollution: May 19–20, 1960, inclusive. Dr. Seymour Crepea, Department of Medicine (Allergy Clinic).

New Faculty at UW

Helen Lathrop Bunge, a native of La Crosse and former student and faculty member of the University of Wisconsin School of Nursing, has been named Director of the School of Nursing, effective June 1.

Other new faculty appointments include: Dr. James Barbour, Assistant Professor of Anesthesiology; Dr. Horace K. Tenney, III, Assistant Professor of Pediatrics; Dr. William Lewis, Associate Professor of Psychiatry; Dr. Clifton Kelly, Assistant Professor of Radiology; Dr. Edward Maibenco, Instructor in Anatomy; Dr. George Brown, Instructor in Physiological Chemistry; Dr. Jack Petajan, Instructor in Physiology; Dr. Arthur Chandler, Instructor in Radiology; Dr. Richard Lende, Instructor in Surgery; and Dr. Albert Grover, Assistant Professor of Preventive Medicine.

Doctor Woolsey on Committee

Dr. Clinton N. Woolsey, Professor of Neuro-Physiology, has accepted an invitation to serve on the Advisory Committee of the Interdisciplinary Brain Research Organization (IBRO) of UNESCO. Lord Adrian, of Cambridge University, England, is chairman of the committee.

Doctor Benjamin to Argentina

Dr. Robert M. Benjamin, Assistant Professor of Physiology, University of Wisconsin Medical School attended the XXI International Congress of Physiological Sciences Meetings in Buenos Aires, Argentina, August 8–15.

UW Grants Accepted

Total gifts and grants accepted by the University of Wisconsin Board of Regents for the Medical School for the 1958–59 fiscal year totaled $2,525,-147.20. Total for the 1957–58 fiscal year totaled $2,202,620.29. This represents an increase of $322,-526.91. These totals do not include the $240,000 in gifts and pledges from Alumni and Faculty for the William S. Middleton Library Fund.

Around the World

Donald W. Smith, Associate Professor of Medical Microbiology, has been invited to present two papers at a "Conference on Antituberculosis Vaccination with Non-Living Vaccines" at Florence, Italy, during the month of September. He will also attend the International Union Against Tuberculosis meetings in Istanbul, Turkey. While in Europe he plans to consult with associated research groups at the Institute de Biologic Physico Chimie, Paris, France, the Microbiological Research Establishment, Salisbury, England and the Pneumoconiosis Unit, Penarth, Glamorganshire, Wales.

Harvard Professor Guest Lecturer

The Department of Medicine of the University of Wisconsin Medical Center presented a lecture by a noted Harvard Professor Monday, August 3, in University Hospitals. James H. Jandl, M.D., Assistant Professor of Medicine, Harvard Medical School, lectured on "Recent Developments in the Field of Hemolytic Anemias."

SK&F Foundation Grant

A report from the trustees of the Smith Kline & French Foundation shows that the University of Wisconsin received a total of $11,500 in grants during 1958. $5,000 was given to support the program of the new head of the Department of Psychiatry, Dr. Robert Roessler, Chairman. $6,500 was given for the purchase of a research spectrophotometer by Dr. Arthur H. Uhl, Dean, School of Pharmacy.

Hartford Foundation Grants

Two Milwaukee institutions were among those who received grants during 1958 from the John A. Hartford Foundation, according to its annual report. Evangelical Deaconess Society of Wisconsin, Deaconess Hospital, received an appropriation of $50,000 for study of hemodynamic and metabolic changes during whole-body perfusion under normothermic and hypothermic conditions. Milwaukee Blood Center, Inc., who had an appropriation balance of $11,900 at the beginning of 1958 had not used the funds and therefore ended the year with the same balance.

Awarded Research Scholarship

William J. Pier, Jr., Brookfield, now in his second year (sophomore) at Marquette University School of Medicine, Milwaukee, has been awarded a $500 scholarship for research and clinical training this summer in the field of allergic diseases by the Allergy Foundation of America.

Mr. Pier intends studying the breathing patterns of patients with hay fever who do not have clinical evidence of asthma, to ascertain if these individuals have any abnormality of breathing which might indicate that there is an associated bronchial disease. The findings could be of great practical importance

(continued)

if they should indicate that hay fever victims do have sub-clinical bronchial disease. He will do this work under the direction of Dr. John A. Arkins, Clinical Instructor in Medicine, Marquette University School of Medicine, and member of the Department of Medicine and Allergy, Milwaukee County Hospital, and Dr. Theodore L. Squier, Associate Clinical Professor of Medicine at Marquette University and Chief, Department of Allergy, Milwaukee County Hospital.

Doctor Ellison Elected to AMA Committee

Dr. Edwin H. Ellison, Professor and Chairman of the Department of Surgery at Marquette University School of Medicine, has been elected Secretary of the Section on Surgery, General and Abdominal, of the American Medical Association. The appointment is for three years and consists of managing correspondence of section and the preparation of the program for each annual meeting.

Alumni Day

Two outstanding guest speakers participated in the fourth annual Wisconsin Medical Alumni Association meetings held May 15 in Madison. Dr. Newell W. Philpott, President of the American College of Surgeons, Montreal, Quebec, spoke on "Doctors and the Present Challenge" and Dr. Michael De Bakey, Chairman of the Dept. of Surgery at Baylor University Medical School, spoke on "Recent Advances in Vascular Surgery."

Doctor Waisman Speaks in Maine

Dr. H. A. Waisman, professor in the Department of Pediatrics, UW Medical School, Madison, was a guest speaker at the First International Medical Conference on Mental Retardation held July 27–31 at Portland, Maine. His topic was, "About Phenylketonuria."

Grants, Fellowships, and Gifts Announced

Research and teaching grants, fellowships, and gifts received for the period April 11, 1959 through June 12 were announced at the quarterly June 12 meeting of the Board of Directors of Marquette University School of Medicine.

A total of $82,100 for research, $11,024 for student fellowships, $4,350 for special projects, $4,269 for a post-sophomore research fellowship, $25,018 for training grants, $1,000 for the medical library, and a $30,000 grant for general educational purposes was received.

Grant Received for Psychiatry

A $3,000 grant in support of the psychiatric program in Milwaukee has been received by Marquette University School of Medicine from the American Fund for Psychiatry, Chicago. The announcement was made by Dr. Eugene S. Turrell, Professor and Chairman of the Department of Psychiatry. The grant became effective July, 1959 and is for one year.

Grants and Fellowships Received from NIH

Grants and fellowships from the National Institutes of Health during the fiscal year 1959 showed that Marquette University School of Medicine received a total of $413,188.

The grants were dispersed as follows: 27 project grants totalling $252,206; 7 teaching grants totalling $94,406; 1 direct traineeship totalling $5,200; 12 full-time research fellowships totalling $52,304; and 14 part-time research fellowships totalling $9,072.

Grant Received for Cardiopulmonary Research in Children

Dr. J. C. Peterson, Professor and Chairman of the Department of Pediatrics, Marquette, has received a $19,440 renewal of a grant from the United States Public Health Service for "cardiopulmonary research in children." The grant was begun September 1, 1957. The present period of renewal study is June 1, 1959 through May 31, 1960. Dr. William J. Gallen, Instructor in Pediatrics, is the director of the laboratory under the grant. The cardiopulmonary laboratory service is available to all children at Milwaukee Children's Hospital seen in the outpatient clinic or through referral from a private physician.

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Medical Meetings - Postgraduate Courses

Mount Sinai Hospital Lectures

The Mount Sinai hospital staff, Milwaukee, is offering a series of lectures for all members of the American Academy of General Practice during October. A total of 24 hours of Category I credit will be allowed.

The courses, primarily for the general practitioner, are entitled: *Newer Concepts in Medicine, Surgery, Obstetrics and Gynecology.*

The first clinical review course will be held on two successive Wednesdays, October 7 and October 14. Course number two will be held on successive Thursdays, October 8 and October 15. Each two-day course offers 12 hours of formal credit. All sessions will be held in the Mt. Sinai auditorium at 948 North 12th Street, Milwaukee.

Registration fee for each course is $25. Sessions will begin at 8:00 a.m. and conclude at 5:00 p.m. each day. The number of physicians who can be accommodated is limited. Those wishing to attend should communicate with the Registrar, Mount Sinai Hospital, Milwaukee, Wisconsin.

Forty board certified specialists will present their discussions. They include: Drs. R. A. Frisch, K. Kaufman, N. Grossman, M. Wagner, M. W. Shutkin, B. E. Urdan, T. J. Greenwalt, A. Pemberton, Joseph Shaiken, M. J. Lustok, M. M. Bortin, S. F. Schwartz, A. M. Kurzon, F. J. Jacobson, D. V. Elconin, R. R. Weller, S. E. Kohn, L. Schwade, J. Chase, J. R. Stone, M. Glicklich, G. D. Straus, B. B. Becker, J. A. Larkey, J. Silbar, L. Gorenstein, L. S. Robbins, R. L. Rice, S. K. Wynn, L. H. Feiman, S. K. Pollack, M. Moel, R. W. Mann, B. Waisbren, J. E. Taxman, R. C. Waisman, E. Epstein, D. Davidoff, H. Giller, M. Sattler, and S. Hurwitz.

Moderators will be: Drs. W. Conen, H. Schumacher, Z. Slomovitz, L. Rothman, A. I. Greenberg, Eugene Usow, and S. Boxer.

Fall Cancer "Scrimmage"

Official notices with registration forms have been sent to all Wisconsin physicians inviting them to participate in the fifth annual fall cancer "scrimmage" scheduled for Saturday, October 24, in Madison. The annual event includes a morning scientific session during which a noted pathologist, Dr. Lauren Ackerman, of St. Louis, Mo., will be a guest lecturer. Participants will take in the Wisconsin–Ohio State football game in the afternoon. This year plans are underway to handle over-night accommodations.

The "scrimmage" is co-sponsored by the Wisconsin Division of the American Cancer Society and the Cancer Research Section of University Hospitals in cooperation with the Wisconsin Medical Alumni Association.

Further particulars may be obtained from Dr. Robert J. Samp, Coordinator, University Hospitals, 1300 University Avenue, Madison 6, Wisconsin.

Michigan State Medical Society

The 94th Annual Session of the Michigan State Medical Society will be held September 29 through October 2 at the Pantlind Hotel in Grand Rapids.

The scientific program will open Tuesday noon and conclude Friday noon. Thirty-one medical teachers will report new developments in research and medical practice.

The scientific program will be augmented by a social evening on Wednesday in the Pantlind Ballroom. At the Officers Night Dinner Dance, M. A. Darling, M. D., of Detroit, will take over the position of MSMS president from retiring G. B. Saltonstall, M. D., of Charlevoix.

James W. Logie, M. D., of Grand Rapids, is General Chairman of the Committee on Arrangements.

Preceding the medical refresher course will be the annual meeting of the MSMS House of Delegates beginning Sunday evening, September 27.

Chicago Diabetes Association

The Chicago Diabetes Association will conduct its third annual symposium on diabetes mellitus at Thorne Hall of Northwestern University, 740 North Lake Shore Drive, on Thursday, October 1.

Dr. Charles H. Best will deliver the Woodyatt Memorial Lecture which will again be a feature of the all-day symposium. The luncheon recess will be used as a discussion period and physicians who wish to do so may reserve a place at one of the discussion tables.

As in previous years, a fee of $25 will be charged for enrollment. Members of the American Diabetes Association, the Chicago Diabetes Association, medical students, interns and residents may attend without charge, but must register for the course.

Inquiries may be addressed to: The Chicago Diabetes Association, 5 South Wabash Avenue, Chicago 3, Illinois.

New York Academy of Medicine

The New York Academy of Medicine will hold its Third Annual Postgraduate Week (formerly the Graduate Fortnight), from Monday, October 5 through Friday, October 9, 1959, inclusive. The title of the program will again be "Research Contributions to Clinical Practice."

Registration, without fee, will be required for non-Fellows of the Academy. All physicians, including interns and residents, and those working in the allied sciences, are welcome.

(continued)

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For further information contact: Secretary, Postgraduate Week, The New York Academy of Medicine, 2 East 103 Street, New York 29, N. Y.

Wisconsin Academy of Pediatricians

The annual meeting of the Wisconsin Academy of Pediatricians will meet Thursday, September 17, in the Wisconsin Center Building on the University of Wisconsin Campus in Madison. The afternoon meeting will feature an internationally-known hematologist, Dr. Irving Schulman, Assistant Professor of Pediatrics at Northwestern University, as guest speaker. The lecture will begin at 4:45 p.m., and is entitled, "Studies on the Formation of Platelets."

American College of Chest Physicians

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present the following postgraduate courses this fall:

14th Annual Course, CLINICAL CARDIOPULMONARY PHYSIOLOGY
Edgewater Beach Hotel, Chicago, October 5–9

12th Annual Course on DISEASES OF THE CHEST
Park Sheraton Hotel, New York City, November 9–13

5th Annual Course on DISEASES OF THE CHEST
Ambassador Hotel, Los Angeles, December 7–11

The course on Clinical Cardiopulmonary Physiology is the second to be presented by the Council on this timely subject. The New York City and Los Angeles courses will offer the most recent advances in the diagnosis and treatment of chest diseases—medical and surgical.

Tuition for each course is $100 including round table luncheon discussions.

Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Minnesota Academy of General Practice

A two-day fall refresher course at the Radisson Hotel in Minneapolis, Minnesota will be held Tuesday, September 22, and Wednesday, September 23, by the Minnesota Academy of General Practice.

The following program is scheduled:

Tuesday afternoon—Edith Potter, M.D., Chicago: "Intrauterine Transmission of Infection to the Fetus"; Herman Kleinman, M.D., Chief of Section Chronic Diseases, Minnesota State Board of Health: "Current Virus Problems"; Ralph Reis, M.D., Chicago: "Endocrine Therapy in Obstetrics and Gynecology—a Re-evaluation"; Kathleen Jordan, M.D., Riverside Sanatorium, courtesy Minnesota Tuberculosis Association: "Chemotherapy in Tuberculosis"; Banquet starts at 6:30 p.m.

Wednesday morning—Raymond Bieter, M.D., Professor and Head, Department of Pharmacology, University of Minnesota: "New Drugs"; George Pack, M.D., New York, courtesy Minnesota Cancer Society: "The Classification and Management of Cancer of the Breast"; Panel, Travis Winsor, M.D., Leader, Los Angeles, Arthur Kerkhof, M.D., Minneapolis, Howard Burchell, M.D., Rochester, and Milton Hurwitz, M.D., St. Paul, courtesy Minnesota Heart Association: "Cardiac Emergencies".

Wednesday afternoon—Leonard Livshin, M.D., Cleveland Clinic, Cleveland, Ohio: "The Tired Mother Syndrome"; Tague Chisholm, M.D., Minneapolis: "Age of Selection for Elective Surgery in Children"; Malcolm McCannel, M.D., Minneapolis: "Office Ophthalmology and the Busy Practitioner"; William Masters, M. D., St. Louis, Mo.: "Basic Research in Female Physiology: The Orgasm".

Reservations and information may be obtained from: Matthew K. Plasha, M.D., Chairman, Coon Rapids Clinic, Coon Rapids, Minnesota.

Fourth International Goiter Conference

The Fourth International Goiter Conference will be held on the Royal College of Surgeons, London, England, July 5–9, 1960. Abstracts of American papers to be considered for presentation should be sent to J. E. Rall, M. D., National Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda 14, Maryland. Abstracts from all other countries are to be sent to Dr. Selwyn Taylor, 3 Roedean Crescent, Roehampton, London, S.W. 3, England.

All American abstracts must be received by Dr. Rall by *December 1, 1959*. They should not exceed 400 words and should be submitted in quintuplicate.

Presentation of papers will be limited to fifteen minutes, and a copy of the final paper must be sent to the London Secretary two weeks prior to the meeting.

Conference on Physicians and Schools

The Seventh National Conference on Physicians and Schools, sponsored by the Department of Health Education of the AMA, will be held at Moraine-on-the-Lake Hotel, Highland Park, Illinois, October 13–15.

Internationally known dinner speakers and special musical numbers include: Tuesday, Oct. 13—I. H. Flack, M.D. Editor of "Family Doctor," Tavistock Square, London, England. Ethel Purlmutter, Pianist. Thursday, Oct. 15—Mr. Homer Wadsworth, Chairman, President's Citizens Advisory Committee on the Fitness of American Youth. Blue Jacket Choir, Great Lakes Naval Training Station.

Significant issues for discussion are:

(1) *National Norms for Fitness, Tuesday, October 13, 1:15 p.m.*
Should we establish national norms based on a test or tests of physical performance, and rate children and youth according to such norms?

(continued)

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A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these model depressions is seen with a rise in the levels of both serotonin and norepinephrine.

A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine levels proportionately.

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Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

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The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

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References

Complete bibliography and Professional Information Booklet are available on request.

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(2) *Time for Teaching—Health and Physical Education, Wednesday, October 14, 8:30 a.m.*
With today's crowded curriculum, how can we find adequate time for health instruction and physical education at the various school levels and how much time is needed?

(3) *Are Periodic Health Examinations of School Children Worthwhile? Wednesday, October 14, 1:15 p.m.*
Do periodic health examinations pay off in terms of the medical manpower they require? Would examinations prior to school entrance, with future examinations dependent on referral by teachers, parents, nurses or others, be a better system?

(4) *Standards of Study for Health Education, Thursday, October 15, 8:30 a.m.*
Should we set up health knowledge, attitudes and behavior standards to be reached at each grade level? Should we establish national minimum standards?

(5) *Classification of Pupils for Physical Education, Thursday, October 15, 1:15 p.m.*
How can we bring about better application of agreed-upon procedure for classifying pupils for physical education and alleviating the problems of medical excuses?

Speakers will introduce and briefly discuss the various aspects of these problems as scheduled. Following the presentation of each of the problems, the issue will be considered by the conferees in small group sessions. A summary session will follow during which the groups may present their questions and comments, and report their decisions.

1960 Meetings of the American College of Surgeons

January—Sectional Meeting, The Brown Hotel, Louisville, Kentucky, January 21, 22, 23. Dr. Rudolf J. Noer, Local Chairman. Address inquiries to: Dr. H. P. Saunders, 40 East Erie Street, Chicago 11, Illinois.

February—Four-day Sectional Meeting for Surgeons and Nurses, The Statler Hilton (Surgeons Hdqrs.) and Sheraton–Plaza (Nurses Hdqrs.), Boston, Massachusetts, February 29, March 1, 2, 3. Dr. Claude E. Welch, Local Chairman. Dr. Anne Kibrick, Chairman, Nurses Program. Address inquiries to: Dr. H. P. Saunders, 40 East Erie Street, Chicago 11, Illinois.

March—Sectional Meeting, The Broadmoor, Colorado Springs, Colorado, March 21, 22, 23. Dr. Edward H. Vincent, Local Chairman. Address inquiries to: Dr. H. P. Saunders, 40 East Erie Street, Chicago 11, Illinois.

Sectional Meeting, Sheraton–Portland Hotel, Portland, Oregon, March 28, 29, 30. Dr. Millard S. Rosenblatt, Local Chairman. Address inquiries to: Dr. H. P. Saunders, 40 East Erie Street, Chicago 11, Illinois.

April—Sectional Meeting, Hotel Leamington, Minneapolis, Minnesota, April 11, 12, 13. Dr. Horace G. Scott, Local Chairman. Address inquiries to: Dr. H. P. Saunders, 40 East Erie Street, Chicago 11, Illinois

Sectional Meeting, Kahler Hotel, Rochester, Minnesota, April 14. Dr. Edward Starr Judd, Jr., and Dr. Joseph H. Pratt, Co-Chairmen. Address inquiries to: Dr. H. P. Saunders, 40 East Erie Street, Chicago 11, Illinois.

October—1960 Clinical Congress, San Francisco California, October 27—November 1.

Epilepsy Institute at Milwaukee

The 11th Western Institute on Epilepsy and the first such institute ever held east of the Mississippi River will be held at Kaiser–Knickerbocker Hotel in Milwaukee on September 10–12. The institute is sponsored by the Variety Club of Wisconsin, the Wisconsin Epilepsy League, and Mount Sinai Hospital of Milwaukee.

The program speakers include Dr. A. Earl Walker, Professor of Neurosurgery, Johns Hopkins University; Dr. Francis M. Forster, Chairman, Department of Neurology, University of Wisconsin; and Dr. William G. Lennox, former Director, Seizure Center, Children's Hospital, Boston, Mass. Areas covered by these authorities and program discussions will include: rehabilitation therapy and diagnosis; social, legal, and medical implications.

Reservations should be made with the hotel and a notification of such to Dr. Jean Davis, Institute Chairman, 312 East Wisconsin Avenue, Milwaukee. Registration fee is $5.00, which includes membership in the institute and a copy of the proceedings.

University of Minnesota Courses

Medical continuation courses to be presented at the Center for Continuation Study, University of Minnesota, are as follows:

Sept. 22–24: Pediatrics for Pediatricians
Oct. 5–7: Obstetrics for General Physicians
Oct. 22–24: Dermatology for General Physicians
Nov. 2–6: Gastrointestinal Radiography for Radiologists

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minn.

American College of OB–GYN

A district meeting of the American College of Obstetricians and Gynecologists will be held October 15–17 at the Sheraton–Fontenelle Hotel, Omaha. Dr. F. J. Hofmeister, 2212 West State Street, Milwaukee 3, Wisconsin, is district chairman. States included in this district are Illinois, Iowa, Minnesota, Nebraska, North and South Dakota, Wisconsin, and Manitoba, Sask., Canada.

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North Shore Hospital Lecture Series

The Tenth Annual North Shore Hospital Lecture Series will be "Office Management of Emotional Disorders." The lectures in the 1959–60 series will be given on the first Wednesday of every month from October through June at the North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois, at 8:00 p.m. The American Academy of General Practice has approved this program for postgraduate training.

The opening lecture will be on Wednesday, October 7, and will be given by John I. Nurnberger, M.D., Professor and Chairman, Department of Psychiatry; Director, The Institute of Psychiatric Research, Indiana University Medical School, Indianapolis, Indiana. His subject will be, "Diagnostic Signs and Symptoms of Emotional Disorders."

All members of the medical professions and allied professional personnel are welcome to attend these public service lectures.

Academy of Psychosomatic Medicine

The sixth annual meeting of The Academy of Psychosomatic Medicine will be held October 15–17 at the Sheraton–Cleveland Hotel in Cleveland. The meeting will be oriented and directed to fit the needs of non-psychiatric physicians. Practical everyday office management of psychosomatic problems and emotional disturbances will be dealt with in formal papers, symposia, panel discussions, and small study groups.

The meeting will be open to all scientific disciplines, as well as psychologists, social workers and nurses. Information may be obtained from Dr. Bertram B. Moss, Suite 1035, 55 East Washington Street, Chicago 2, Illinois.

Other Dates to Remember

Sept. 28–Oct. 2—45th annual Clinical Congress of the American College of Surgeons, Atlantic City, N. J.

Sept. 13–17—24th annual Congress of the North American Federation, International College of Surgeons, Palmer House, Chicago, Ill.

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SURGERY—Surgical Technic, Two Weeks, September 21, October 19
Surgery of the Colon and Rectum, One Week, September 21
Thoracic Surgery, One Week, October 19
General Surgery, One Week, October 26
Board of Surgery Review Course, Part I, Two Weeks, October 5
Fractures and Traumatic Surgery, Two Weeks, October 12

GYNECOLOGY AND OBSTETRICS—Office and Operative Gynecology, Two Weeks, September 28
Vaginal Approach to Pelvic Surgery, One Week, October 12
General and Surgical Obstetrics, Two Weeks, September 14

MEDICINE—Electrocardiography, Two-Weeks Basic Course, October 5
Gastroscopy & Gastroenterology, Two Weeks, September 14
Internal Medicine, Two Weeks, October 19

UROLOGY—Two-Week Intensive Course, October 26
Ten-Day Practical Course in Cystoscopy, by appointment

RADIOLOGY — Clinical Uses of Radioisotopes, Two Weeks, September 21

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H. W. Aufderhaar, 38 South Water Street, Fort Atkinson.

D. A. Sallis, Boyd.

D. R. Griffith, 314 East Grand Avenue, Eau Claire.

R. F. Wichser, 921–16th Avenue, Monroe.

A. Y. Gerol, 1336–25th Avenue, Monroe.

S. H. Holt, Kenosha Hospital, Kenosha.

H. R. Christofersen, 712 Bellinger, Eau Claire.

R. A. Stanley, 700 Second Street, West, Ashland.

T. M. Shearer, Poser Clinic, Columbus.

R. A. Songe, Medical Arts Building, Wausau.

Mary C. Berkley, 94 Ruger Heights Road, Janesville.

A. O. Tuftee, Beloit Clinic, Beloit.

G. B. Ellenz, St. Francis Hospital, La Crosse.

D. G. Tompkins, 1836 South Avenue, La Crosse.

E. S. Orman, 2727 North 52nd Street, Milwaukee.

J. F. Koppa, *Turville Point, Madison.

R. W. Olson, 3614 Sargent Street, Madison.

B. C. Wheeler, Jr., 4357 Britta Parkway, Madison.

F. G. Blum, Jr., 110 East Main Street, Madison.

D. D. Miller, 2101 Sixth Street, Monroe.

F. N. Roemhild, Medical Arts Building, Prairie du Sac.

G. B. Theil, *Metabolic Research Unit, Ward 46A, U. S. Naval Hospital, Oakland, California.

J. R. Bischel, Dousman.

G. K. Boyd, 30 South Henry Street, Madison.

L. G. Crocker, 2205 West Lawn, Madison.

William Kiekhofer, 1300 University Avenue, Madison.

L. O. Lund, 1300 University Avenue, Madison.

T. S. Roberts, 1300 University Avenue, Madison.

S. M. Woods, 1300 University Avenue, Madison.

C. E. Elson, 3001 North 39th Street, Milwaukee.

R. L. Leverenz, 159 East Fairmount Avenue, Milwaukee.

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The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, April 17, 1959.

Name	*School of Graduation*	*Year*	*City*
Botticelli, J. T.	Stritch School of Medicine	1955	Milwaukee
Cameron, D. M.	University of Manitoba	1955	Hettinger, North Dakota
Corser, D. H.	Washington University	1954	La Crosse
Cozine, R. L.	University of Chicago	1954	Berlin
Engels, E. P.	University of Minnesota	1948	Rice Lake
Green, J. M.	Northwestern University	1952	Madison
Greene, R. C.	Washington University	1934	Manitowoc
Hanrahan, J. P.	Tulane University	1955	Chicago, Illinois
Haydary, A. L.	University of Illinois	1948	Chicago, Illinois
Jirsa, H. O.	University of Iowa	1935	Cedar Rapids, Iowa
McClellan, W. A.	Western Reserve University	1943	Milwaukee
Morledge, J. H.	Western Reserve Universtiy	1952	Madison
Oliveira, Elizabeth M.	Tulane University	1956	Superior
Olson, L. L.	University of Washington	1954	St. Paul, Minnesota
Orvis, R. C.	University of Iowa	1953	Dubuque, Iowa
Ottum, J. A.	Northwestern University	1953	Detroit, Michigan
Purcell, H. K.	University of Pennsylvania	1937	St. Louis, Missouri
Roemhild, Franklin	University of Illinois	1949	Prairie du Sac
Roley, E. L.	Creighton University	1956	Des Moines, Iowa
Waters, H. S.	Columbia University	1932	Marshfield
Weber, J. W.	University of Nebraska	1956	New London

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

The Integration of Behavior. Volume III: The Reintegrative Process in a Psychoanalytic Treatment. By Thomas M. French, M.D., Director of Research at the Chicago Institute for Psychoanalysis, University of Chicago Press, 5750 Ellis Avenue, Chicago 37, Illinois. 1958. 484 pages. Price: $10.00.

This book is the third in a series of five. The first book was largely a theoretical exposition of Doctor French's view of human behavior and the second was an examination of how the theoretical concepts discussed in the first volume are revealed in the content of dreams. This volume continues such examination in the broader context of all the aspects of psychoanalytic treatment.

Although the author states in his foreword to this volume that he has several kinds of readers in mind, he does not specify what kinds. In the reviewer's opinion, none of these volumes is suitable for the general reader nor for the physician who is not a psychiatrist. The intent of the author seems to be to make a contribution to a theory of the processes of change in the course of psychoanalysis. As such, it is unlikely to be seen as useful or even interesting to readers other than psychiatrists.

Indeed, many psychiatrists will find this book lacking. It does not seem to be the novel contribution the author apparently hopes it will be. Moreover, the writing seems to lack clarity and is unnecessarily wordy. On the positive side, the therapist particularly interested in the symbolism of dreams and the usefulness of dreams in the treatment process, will find extensive discussion of this topic.—ROBERT ROESSLER, M.D.

Neurological Basis of Behavior. Ciba Foundation Symposium. By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc., editors for the Ciba Foundation. Little Brown & Company, Boston, Mass. 1958. 109 illustrations. 400 pages. Price: $9.00.

The study of neurological bases of behavior has many and diverse aspects, as is well exemplified in the 19 papers of this symposium held in 1957 in commemoration of Sir Charles Sherrington. This volume is to be recommended for graduate and medical students or others interested in becoming familiar with current theory, problems and methodology in the general field of neuropsychology. The research reported and extensively discussed by the 34 participants clearly demonstrates the use of several basic techniques by means of which can be identified: (1) effects on behavior of CNS lesions; (2) effects on behavior of stimulation of particular portions of the CNS; (3) effects on behavior and on concomitant neural activity of hormonal, chemical, and pharmacological agents; and (4) correlation of patterns of electrical activity of particular neural masses with coincident behavioral patterns. The reader can appreciate how these techniques have been used effectively to identify the role of a few cortical, thalamic and hypothalamic, rhinencephalic, and brainstem structures in learning, motivation, attention, and behavioral arousal and patterning. Correlations between neural activities and behavioral components are frequently indicated; anatomical localization of regions of activity or inactivity important in the motivation and integration of behavior are suggested; and the localization of certain neural masses particularly susceptible to various biochemicals which affect behavior is attempted. Although the data reported concern the function of only a few of the most prominent central neural masses, and although detailed consideration of anatomical features is frequently omitted, the application of the basic techniques serves as a model. Many references to the literature serve to guide the interested reader further. The discussions following the reports are outstanding in that they nicely point out controversial topics and indicate knotty conceptual and methodological issues. This volume is not systematically organized in customary textbook style. The subject matter is perhaps too new for this. Indeed, the content of the reports and the discussions following them illustrate the existence of extensive gaps in the fundamental body of knowledge in this blossoming and highly exciting field.—W. I. WELKER, PH.D.

NEW BOOKS RECEIVED

Gynecologic Radiography. By Jean Dalsace, M.D., Chief of Sterility Service, Broca Hospital, University of Paris, Paris, and J. Garcia-Calderon, M.D., Radiologist, University of Paris School of Medicine, Paris. A Chapter on *Radiography of the Breast.* By Charles-M. Gros, M.D. and Robert Sigrist, M.D. Translated by Hans Lehfeldt, M.D. Paul B. Hoeber, Inc., 49 E. 33rd Street, New York. 1959. 188 pages. 305 illustrations. Price: $8.00.

Textbook of Surgery. Edited by H. Fred Mosely, M.A., D.M., M.Ch. (Oxon), F.A.C.S., F.R.C.S. (Eng.), F.R.C.S. (C), Assistant Professor of Surgery, McGill University; Associate Surgeon, Royal Victoria Hospital, Montreal, Canada. Third Edition. The C. V. Mosby Company, St. Louis, 1959. 1285 pages. 738 Text Illustrations. 108 Color Plates. Price: $17.00.

(continued)

The Measurement and Appraisal of Adult Intelligence. By David Wechsler, Chief Psychologist, Bellevue Psychiatric Hospital, Adjunct Professor of Psychology, Graduate School of Arts and Science, New York University College of Medicine. Fourth Edition. The Williams & Wilkins Company, Baltimore. 1958. 255 pages. Price: $5.00.

Hearing, A Handbook for Laymen. By Norton Canfield, M.D., Associate Clinical Professor of Otolaryngology, Yale University School of Medicine, President of the Audiology Foundation. Doubleday & Company, Inc., Garden City, New York. 1959. 214 pages. Price: $3.50.

Amino Acids and Peptides with Antimetabolic Activity. Ciba Foundation Symposium. By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B. Sc., Editors for the Ciba Foundation. Little Brown & Company, Boston, Mass. 1958. 28 illustrations. 277 pages. Price: $8.75.

Questions and Answers in Anatomy. By Stanley D. Miroyiannis, B.S., M.A., Ph.D., F.A.A.A.S., F.I.A.S., Professor of Anatomy and Chairman of the Department, Still College. Vantage Press, Inc., 120 W. 31 Street, New York 1, New York. 1959. 322 pages. Price: $5.00.

Maternity, A Guide to Prospective Motherhood. By Frederick W. Goodrich, Jr., M.D., Illustrated by Victor Mays. Prentice–Hall, Inc., Englewood Cliffs, New Jersey. 1959. 127 pages. Price: $1.75.

Biosynthesis of Terpenes and Sterols. Ciba Foundation Symposium. By G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B. Sc. Little, Brown and Company, Boston, Mass. 1959. 102 illustrations. 303 pages. Price: $8.75.

Pediatric Neurology. By Stanley S. Lamm, M.D., Clinical Professor of Pediatrics, State University of New York College of Medicine; Neurological Consultant, Pediatric Department, Kings Country Hospital, Brooklyn, New York; Formerly Instructor in Neurology, Long Island College of Medicine, Brooklyn, New York; Director, Cerebral Palsy Clinic, Long Island College Hospital, Brooklyn, New York. Landsberger Medical Books, Inc., New York. 1959. 482 pages. 22 illustrations.

Urology in Outline. By T. L. Chapman, Ch.M., F.R.C.S. (Eng.), F.R.F.P.S. (Glas.), Honorary Clinical Lecturer in Urology, University of Glasgow; Urological Surgeon, Victoria Infirmary, Glasgow; Urological Surgeon, Hairmyres Hospital, Lanarkshire; Urological Surgeon, Ballochmyle Hospital, Ayrshire. E. & S. Livingstone Ltd., Edinburgh. 1959. Williams & Wilkins Company, Baltimore, Agents. 173 pages. 138 illustrations. Price: $6.75.

Childbearing Before and After Thirty-Five. By Adrien Bleyer, M.D., Associate Professor Emeritus of Clinical Pediatrics, Washington University School of Medicine, St. Louis, Missouri. Vantage Press, Inc., 120 West 31st Street, New York. First Edition. 1958. 119 pages. 17 tables. Price: $2.95.

A History of Ophthalmology. By George E. Arrington, Jr., M.D., Associate in Ophthalmology and Attending Ophthalmologist, Medical College of Virginia, Richmond Eye Hospital, Retreat for the Sick Hospital, and the Richmond Memorial Hospital, Richmond, Virginia. MD Publications, Inc., New York. 1959. MD monographs on Medical History, Number Three. 164 pages. Price: $4.00.

Your Mind Can Make You Sick or Well. By Curt S. Wachtel, M.D., New York. Prentice–Hall, Inc., Englewood Cliffs, New Jersey. 1959. 238 pages.

Insulin Treatment in Psychiatry. By Max Rinkel, M.D., Boston, and Harold E. Himwich, M.D., Galesburg, Illinois, Editors. Proceedings of the International Conference on the Insulin Treatment in Psychiatry Held at the New York Academy of Medicine, October 24–25, 1958. Philosophical Library, Inc., 15 East 40th Street, New York, New York. 1959. 381 pages. Price: $5.00.

A History of Neurology. By Walther Riese, M.D., Associate Professor of Psychiatry and Neurology; Associate Professor of the History of Medicine; Chairman of the Department of the History of Medicine; Medical College of Virginia, Richmond, Virginia. MD Publications, Inc., New York. 1959. MD Monographs on Medical History, Number Two. 211 pages. Price: $4.00.

The Plasma Proteins, Clinical Significance. By Paul G. Weil, B.A., M.D.C.M., M.Sc., Ph.D., Director, Transfusion Service and Assistant Physician, Royal Victoria Hospital; Lecturer in Medicine, McGill University; Consultant in Medicine, Queen Mary Veterans and Grace Dart Hospitals; Consultant in Transfusion, Queen Elizabeth and Royal Edward Laurentian Hospitals. J. B. Lippincott Company, Philadelphia. 1958, 1959. 122 pages. Price: $3.50.

Now or Never, The Promise of the Middle Years. By Smiley Blanton, M.D. with Arthur Gordon. Doctor Blanton is a Diplomate of the American Board of Psychiatry and Neurology, Associate Founder and Director of the American Foundation of Religion and Psychiatry, and Director of the Religo-Psychiatric Clinic of the Marble Collegiate Church. Prentice–Hall, Inc., Englewood Cliffs, New Jersey. 1959. 273 pages. Price: $4.95.

Neurosurgery, Volume I. Prepared and published under the direction of Major General S. B. Hays, Surgeon General, United States Army. From Clinical Series on Surgery in World War II by the Medical Department of the United States Army. Office of the Surgeon General, Department of the Army, Washington, D.C. 1958. 428 pages. 130 illustrations. 19 tables. Price: $5.00.

The Ecology of Human Disease. By Jacques M. May, M.D., Director, Medical Geography Department, American Geographical Society, New York. MD Publications, Inc., New York. 1958. 298 pages. Tables. Price: $7.50.

Fracture Surgery, A Textbook of Common Fractures. By Henry Milch, M.D., Emeritus Attending and Consulting Orthopedic Surgeon, Hospital for Joint Diseases, New York, and Robert Austin Milch, M.D., Assistant Resident Surgeon, Peter Bent Brigham Hospital, Boston. With a chapter on Anesthesia by Herbert D. Dubovsky, M.D., Director of Anesthesiology, Easton Hospital, Easton, Pennsylvania. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 49 East 33rd Street, New York 16, New York. 1959. 671 illustrations. 459 pages. Price: $17.50.

New and Nonofficial Drugs. Containing Description of therapeutic, Prophylactic and Diagnostic Agents Evaluated by the Council on Drugs of the American Medical Association. J. B. Lippincott Company, Philadelphia. 1959. 673 pages.

Antibiotics Annual, 1958–1959. Proceedings of the Sixth Annual Symposium on Antibiotics. Henry Welch, Ph.D. and Felix Marti–Ibanex, M.D., Editors. Medical Encyclopedia, Inc., New York, New York. 1959. 1091 pages. Tables and illustrations. Price: $12.00.

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PITOCIN: Its Administration and Medical Supervision

Editor's Note: The Maternal Mortality Study Committee of SMS has expressed concern over the administration of "Pitocin", and the necessity for physicians and nursing supervisors to understand fully the potential dangers of "Pitocin" in obstetrics. A series of letters regarding this situation is reproduced below.

To Chiefs of Medical Staffs Wisconsin Hospitals:

Inquiry has been directed to the Division on Maternal and Child Welfare as to whether or not a physician should properly assign to a nurse the responsibility of medical management following the administration of "Pitocin" during the course of labor, prior to delivery.

It is important to re-emphasize to all physicians that the administration of "Pitocin", or any oxytocics, in relation to obstetrics is a medical procedure which should under no circumstances be delegated to the nurse or other non-medical personnel without direct and continuing medical supervision.

If the administration is ordered by a physician, he should be in attendance at the time the oxytocic is administered, and he should either be in direct attendance of the patient until after delivery or be in such close proximity to the patient that he can be reached and provide attention to the patient within a few minutes after an obstetrical emergency arises.

It would be desirable to have all medical staffs of hospitals include in their hospital regulations the matter of administration of oxytocics and the required supervision of the attending physician until delivery has been completed.

The Maternal Mortality Survey has provided the Study Committee with several instances where the administration of oxytocics, particularly "Pitocin", has resulted in spontaneous delivery with resultant lacerations of the uterus. Obviously, such obstetrical emergencies require immediate medical supervision and control beyond the capacity and scope of authority of the nurse.

The Division on Maternal and Child Welfare urges that you consider a statement in your hospital medical staff rules providing the medical supervision in the administration of all oxytocics and medical supervision of the patient until after delivery has been achieved.

George S. Kilkenny, M.D.
Chairman, Division of Maternal and Child Welfare

To Doctor Kilkenny:

At our quarterly Staff Meeting last evening, the letter we received from you regarding the medical management (whose responsibility it is in carrying it out) following administration of "Pitocin", or any oxytocics, during the course of labor, prior to delivery, was read and discussed.

Our hospital is a 75-bed general hospital which has no doctor on 24-hour duty.

The Staff is wondering whether a physician may order "Pitocin", or any oxytocic, intramuscularly for induction of labor and safely leave the hospital, or should they be expected to remain in the hospital from the time the oxytocic is administered intramuscularly until after the delivery?

As Chief of Staff, I wish to clarify this point and would appreciate hearing from you.

----------, M.D.
Chief of Staff

To Doctor:

Inasmuch as I was meeting with other members of the Maternal Mortality Study Committee on June 23–24–25 for a teaching circuit, I wished to discuss your letter with them and give you and your associates our best collective thoughts on the question you have raised.

First, Doctor, permit me to emphasize that the Study Committee of the Maternal Mortality Survey is in no sense a policy-making body. We have no authority to tell any physician or group of physicians what he or they *must* do in their medical practice. Nor can we tell hosiptals what they *must* do. Our only function and purpose is to present problems which have been revealed in the course of our study of maternal deaths in Wisconsin since 1953, and to make recommendations which we feel might best meet these problems.

The matter of administration of "Pitocin" has been of great concern to us, and on the basis of our review of maternal deaths in which the administration of "Pitocin" played a significant role, we asked permission of the Council of the State Medical Society to issue a statement to all Chiefs of Medical Staffs of Wisconsin Hospitals concerning this problem and our recommendations—and I wish to re-emphasize the word recommendations—not orders.

By review of my letter which prompted your letter you will note that the communication makes two points: (1) that the administration of "Pitocin" is a medical procedure and under no circumstances should be delegated to a nurse or other non-medical personnel "without direct and continuing medical supervision"; (2) by "continuing medical supervision" we do not mean that the physician must stay by the bedside of the patient continuously until labor has been completed, but we do know that the action of "Pitocin" is of such a varying nature that it may present emergencies which are beyond the scope of the nurse to properly meet. As the third paragraph of my letter points out, "he (the physician) should either be in di-

(continued)

rect attendance of the patient until after delivery or be in such close proximity to the patient that he can be reached and provide attention to the patient within a few minutes after an obstetrical emergency arises."

The emphasis of the importance of continuing medical supervision was made only after careful analysis of our experience with the Maternal Mortality Survey.

Our studies show "Pitocin" to be a drug of potent characteristics and its use in the FIRST or SECOND stage of labor involves a calculated risk. The risk of intramuscular administration of the drug creates greater risk, since when once given, it cannot be retrieved, and therefore, cannot be controlled.

Even when small repeated doses are administered intramuscularly, the effect cannot be predicted because of disparity between individual patient's response and variable standardization of the drug. Administration by means of dilute intravenous drip method also carries a calculated risk, but has a greater safety factor since the rate of utilization can be controlled, and its effect terminated by discontinuing the flow of the intravenous solution.

During the course of our Study the past six years, we have been impressed with the traumatic effects of the administration of "Pitocin" where not properly controlled. We have studies of several cases of ruptured uteri and extensive lacerations which appear to be closely associated with the administration of this drug. We all recognize its proper role, and I do not wish to convey the impression that "Pitocin" should not be used under any circumstances, but the observations made are based upon your inquiry.

All we wish, Doctor, is that medical staffs of hospitals discuss this problem and agree on procedures which are in keeping with local situations. However, regardless of the size of the hospital or the size of the medical staff, it is the strong feeling of the Study Committee that rules established should provide the maximum protection of the patient, in light of the known action of "Pitocin" and other oxytocics used in obstetrics.

We are not telling you or your medical staff what you must do. All we are doing is to point out the problem, and we know that in your collective good judgment, you will establish rules at your hospital which will assure obstetrical patients of careful medical supervision whenever "Pitocin" is used.

GEORGE S. KILKENNY, M.D.
Chairman, Division of Maternal and Child Welfare

Prenatal Facts

SUGGESTED PROCEDURE — File at hospital in last month of pregnancy. If there are indications of possible premature delivery file earlier. Direct this form to the supervisor of obstetrics of the hospital to which the patient will be admitted.

Name _____ Address _____ igion _____

Expected date of confinement _____ -- Para _____

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STATE MEDICAL SOCIETY OF WISCONSIN — MEDICINA NUSQUAM NON EST

County Society Proceedings

POLK

Eighteen members of the Polk County Medical Society met July 16 as dinner guests of *Dr. David Maas* of Webster. The meeting was held at Perry's on Clam Lake in Siren. Mr. David C. Reynolds from the staff of the State Medical Society spoke to the group on legislative action of interest to the medical profession. A round table discussion followed.

RACINE

On the afternoon of July 22 the Racine County Medical Society held its annual family picnic at Johnson Park in Racine. Festivities included pony rides and games for the children, baseball, and a lunch wagon which was present all afternoon.

RICHLAND

On August 6 eight members of the Richland County Medical Society met at the cottage of *Dr. R. E. Housner* in Muscoda. Guest speaker for the evening was Mr. Earl Thayer, of the State Society staff, who spoke on legislative subjects.

News from the Specialty Societies

Wisconsin Society of Plastic Surgery

Specialists in plastic surgery have formed a new organization called the Wisconsin Society of Plastic Surgery. The following officers have been elected:

President: *Dr. Christopher R. Dix*

Vice-president: *Dr. William Frackelton*

Secretary-Treasurer: *Dr. Jack Teasley*

Board of Directors: *Drs. Volney B. Hyslop, Frank D. Bernard,* and Paul Natvig.

Physicians whose names appear in italics are members of the Society.

Wisconsin Society of Pathologists

A paper on the diagnosis of cancer by means of measuring the amounts of an enzyme, lactic dehydrogenose, was presented by *Dr. Edwin L. Bemis* at the June meeting of the Wisconsin Society of Pathologists. The society met at the Madison General Hospital. Doctor Bemis is currently completing his fourth year of pathology training at the Veterans Administration Hospital, Wood.

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News of Wisconsin Physicians

Manitowoc Clinic Has New Physician

Having recently completed specialty training, Dr. Robert I. Bush, a pediatrician, has joined the staff of the Manitowoc Clinic. Doctor Bush moved to Manitowoc after spending two years at the Akron Children's Hospital. Previously he had received a medical degree from the University of Minnesota in 1956 and interned at City Hospital in Akron, Ohio.

Doctor Hildebrand on "Who's Who" Board

Dr. W. B. Hildebrand, president of SMS, has been named to the honorary advisory board of the "Who is Who in Wisconsin." The book, scheduled to be published in early 1960, is the first statewide biographical reference ever published in Wisconsin.

Osceola Clinic Adds Dr. Dale Scott

Coming to Osceola after a year of internship at Ancker Hospital in St. Paul, Minnesota, Dr. Dale T. Scott began his duties as physician at the Osceola Clinic. Doctor Scott graduated in 1958 from the University of Michigan Medical School.

Doctor Hammer Joins River Falls Clinic

Dr. Roland Hammer has been added to the staff of the River Falls Clinic. He replaced Dr. L. O. Furr who now practices in Bird Island, Minnesota.

A former pharmacist, Doctor Hammer entered medical school after receiving a 1951 degree from the Minnesota School of Pharmacy, serving in the U.S. Army, and working a year at Madison, Minnesota, as a registered pharmacist. Graduating in 1958 from the University of Minnesota School of Medicine, Doctor Hammer interned at Harbor General Hospital in Torrance, California.

Doctor Fieber Goes to Fond du Lac

On August 1 *Dr. Warren Fieber* left Lancaster, where he had been located for the past three years in association with *Dr. R. D. Jackson*, to join the Gavin Clinic in Fond du Lac. Prior to establishing his Lancaster practice, Doctor Fieber had graduated from the University of Wisconsin Medical School and interned at Winston–Salem, North Carolina.

Dedicate Camp Building in Honor of Doctor

In July dedication ceremonies of an infirmary building at Camp Chickagami, a Portage County Boy Scout Camp, were held in honor of the late Dr. F. X. Pomainville. Cost of the 16x24-foot building, which will be used primarily as a first aid dispensary, was partially underwritten by the doctor. It will be known as the F. X. Pomainville Center.

Doctor Rosemeyer Relocates in State

A Spring Green physician, *Dr. O. G. Rosemeyer*, has moved to Rhinelander where he is now a member of the Schiek Clinic. Born in Loeningen, Germany, Doctor Rosemeyer is a graduate of the University of Berlin School of Medicine. He has received specialty training in pathology, general surgery, orthopedic surgery, and gynecology at several hospitals in Germany. In 1955 he went to Winnipeg, Canada, where he was on the staffs of Misericordia and Municipal Hospitals and came to Spring Green in 1957.

Doctor Giffen Locates in Eau Claire

Dr. Guy G. Giffen, who has been a resident general practitioner at Luther Hospital in Eau Claire for the past year, has joined *Drs. Raymond Richards* and *R. M. Lotz* in their Eau Claire offices.

Doctor Giffen received a B.A. degree from Miami University at Oxford, Ohio, in 1952, where he was an assistant in the department of zoology. His medical degree was obtained at the University of Cincinnati in 1957 and he interned at St. Luke's Hospital, Denver, Colorado.

Neurosurgeon Moves to Wausau

It was recently announced that Dr. L. M. Williamson has opened an office in Wausau for the practice of neurosurgery. For the past ten years Doctor Williamson has been practicing in his native city of Santiago, Chile.

Doctor Williamson received his medical education at the University of Chile, graduating in 1941. He interned at the Massachusetts General Hospital in Boston, took his residency at the Mayo Clinic, and in December, 1946, received a master of science degree in neurosurgery from the University of Minnesota.

Publisher of several research papers in his field, Doctor Williamson was one of the founder members of the Congress of Neurological Surgeons. He is also a member of the National Multiple Sclerosis Society, the Mayo Foundation Association, and the College of Doctors.

Doctor Lyne to Take Training

As of October 1 *Dr. B. W. Lyne* will discontinue his private practice in Neillsville to enter residency at the Mayo Foundation in Rochester. Doctor Lyne is entering the postgraduate work in pathology after five years at Neillsville.

La Crosse Doctor Honored

The first Distinguished Alumnus Award given by River Falls State College was recently awarded to *Dr. Dean S. Smith* of La Crosse, a 1909 graduate of

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the city's college. An eye, ear, nose and throat specialist, Doctor Smith was granted the award as one "who has made a definite contribution to his profession, has participated in the civic life of his community, and who has shown continuous interest in his college."

Doctor Rahr Begins Practice

In July Dr. Henry Rahr became associated with *Dr. H. E. Majeski* in the medical clinic of Luxemburg. A native of Green Bay, Doctor Rahr also uses *Dr. Alvin Brusky's* Green Bay office from time to time. After graduating from the University of Wisconsin he interned at St. Luke's Hospital, in Duluth, Minnesota.

Doctor Newton Addresses Rotary

The Hudson Rotary Club heard *Dr. J. E. Newton* of that city tell of his experiences while attending the Rotary International Convention in New York. Describing it as an inspiring meeting, Doctor Newton said, "The international scope of the organization was clearly illustrated at the convention."

New Green Bay Doctor in Practice

An obstetrician and gynecologist, Dr. F. W. Jansen, has joined *Dr. J. J. Boersma* of Green Bay. Doctor Jansen graduated from the University of Wisconsin Medical School and took both his internship and residency at Charity Hospital, New Orleans, Louisiana.

Third Doctor Joins Cadott Clinic

Beginning July 20 Dr. Clifford Bowe was added to the staff of the Cadott Medical Center, practicing with *Drs. C. E. Zenner* and *B. J. Haines.* A 1958 graduate of Marquette University School of Medicine, Doctor Bowe interned at St. Mary's Hospital, Madison. With his arrival it is anticipated that morning office hours will be maintained at the clinic each week day.

Doctor Sandmire in Practice

Dr. Herbert Sandmire has begun his first practice with *Dr. S. D. Austin* of Green Bay. Upon graduation from the University of Wisconsin Medical School in 1953, he entered the U.S. Air Force. Doctor Sandmire was released in 1956 and went to Iowa City, Iowa, as a resident in obstetrics and gynecology at the University Hospitals. While taking this training he published two scientific papers on coagulation difficulties in pregnancy and tubal pregnancy.

Doctor Schmitt Given Farewell Party

The Phelps High School was the site of a party given by the citizens of the area in honor of *Dr. R. W. Schmitt* before he left for Topeka, Kansas, this summer. Doctor Schmitt had served the community of Phelps for the past twelve years and both he and his wife had been active in community affairs.

Doctor Bruhn Comes to Walworth

Dr. I. J. Bruhn established an office in Walworth around August 1 for the practice of medicine. Prior to interning at Rockford Memorial Hospital, Rockford, Illinois, Doctor Bruhn received his medical education at the University of Wisconsin, graduating in 1958. He had received a Bachelor's Degree from Wisconsin and took two years of graduate study there before entering the medical profession.

Tribute Paid to Doctor Rogne

On July 12 the Ettrick American Legion sponsored a "Tribute to Doctor Rogne" day. More than 700 residents of the area attended the celebration held at *Dr. C. Oliver Rogne's* farm location outside Ettrick. The doctor has been in the medical profession for over 40 years, coming to Ettrick in 1923 following discharge from the U.S. Navy and practices in South Dakota and Garden City.

A short program was presented during which Doctor Rogne was given a plaque in appreciation of his service to Trempealeau county. Music was provided by the Galesville City band and lunch was served. Persons who were "Doctor Rogne Babies" were asked to register and the total showed that 204 were present, the youngest born in March and the oldest, a son, born in 1923.

Doctor Gundersen on Index Committee

Dr. Gunnar Gundersen, immediate past president of the American Medical Association, has accepted membership on the Medical Advisory Committee of the National Disease and Therapeutic Index (N.D.T.I.) medical statistical research program it was announced recently by Dr. George Morris Piersol, Medical Director.

The N.D.T.I., with headquarters at 8600 Prospect Avenue, Philadelphia, Pa., was organized four years ago to fill the need for a continuous flow of up-to-date, factual information on the illnesses, injuries and other conditions for which patients see doctors, and the treatments which they receive. Currently, some twelve hundred doctors participate in the program annually, providing important data for use in research and education. A similar program has been established recently in Germany, and others are planned in Canada, Great Britain, France and other areas in the near future.

Surgeon Added to Midelfart Clinic Staff

The Midelfart Clinic, Eau Claire, has announced the addition of Dr. James W. Merritt to its staff. Doctor Merritt will specialize in surgery.

Doctor Merritt was born January 23, 1924, at Mount Pleasant, Iowa. He attended Antioch College at Yellow Springs, Ohio, for two years. Doctor Merritt then served in the U. S. Army for three years during World War II. Following his military service he received B.A. and M.S. degrees from the University of Iowa, Iowa City. In 1952 he received his M.D. degree from the same University.

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Doctor Merritt served his internship at Youngstown City Hospital, Youngstown, Ohio. Following this he served a year's residency at Luther Hospital, Eau Claire, and also was associated with the Midelfart Clinic for a year. For the past four years he has been training in general surgery, a year of which was spent in chest surgery at the Veterans Administration Hospital and the University of Minnesota Hospitals in Minneapolis.

THIRD AND TWELFTH DISTRICTS

Jackson Clinic Has New Doctor

An obstetrician and gynecologist, Dr. R. E. Wheatley, recently joined the staff of the Jackson Clinic, Madison, Doctor Wheatley came to Madison after serving a year of pathology residency at the Baptist Memorial Hospital in Jacksonville, Florida, where he did gynecologic research. Previously he had received a degree in 1954 from McGill University Faculty of Medicine, interned at South Pacific General Hospital, and served a residency in his specialty at Mary's Help Hospital and Stanford University Hospitals in San Francisco, California.

Dr. Wheatley

Doctor Gredler Returns to Janesville

Having recently completed a three-year orthopedic residency in Milwaukee, *Dr. G. P. Gredler* has returned to Janesville to practice with *Drs. George Thomas* and *Paul Odland.* His residency had been served at the Veterans Administration Hospital, Wood, Milwaukee Children's and Milwaukee County Hospitals.

Prior to going to Milwaukee, Doctor Gredler had a general practice in Janesville from 1952 to 1955 and had one year of general surgery residency at Mercy Hospital, Janesville. He is a 1951 graduate of the University of Wisconsin Medical School.

The Cookseys Vacation

In July *Dr.* and Mrs. *R. T. Cooksey* of Madison vacationed in Hawaii. Traveling by boat, they sailed from Los Angeles.

Dean Clinic Adds Doctor Botham to Staff

Dr. R. J. Botham has left his post as instructor in surgery at the University of Wisconsin, a position he has held since 1957, to join the Dean Clinic, Madison. He will practice as a general surgeon specializing in heart surgery.

A 1952 graduate of the University of Wisconsin, Doctor Botham interned at C. P. Miller Hospital, St. Paul, Minnesota, and took a general surgery residency at the Mayo Clinic. He is a diplomate in the American College of Surgeons.

Gynecologist Affiliates with Beloit Clinic

The Beloit Clinic has added Dr. Walter A. Scholten to its staff in the department of gynecology. Doctor Scholten graduated from medical school at Northwestern University in 1954, interned at Chicago Wesley Memorial Hospital, and took four years of residency, including 18 months at the Chicago Maternity Center, six months of gynecologic pathology at Northwestern and a year at Wesley Hospital in obstetrics. He was in the military service for 19 months during World War II.

Kiwanis Club Hears Doctor Samp

The Kiwanis Club of Madison West met July 17 for a luncheon at the Cuba Club and to hear an address by *Dr. Robert Samp* of Madison, medical director of the Wisconsin Division of the Cancer Society. He chose "The Facts of Life" as his subject.

Doctor Walsh Opens Madison Practice

Dr. LeRoy Walsh, a 1958 graduate of the University of Wisconsin, has opened an office in Madison for the practice of general medicine. His internship at St. Mary's Hospital, Madison, was completed this year.

Two New Doctors in Monroe

The Monroe Clinic has added two new physicians, Drs. Hugh Williams and Thomas Cooper, to the staff.

A dermatologist, Doctor Cooper recently completed three years as a resident at the VA Hospital, Wood. His postgraduate work included teaching at Marquette University, from where he had graduated from medical school, and in January, 1959, had been appointed to the teaching staff as instructor in the Department of Dermatology. Before obtaining his higher education, Doctor Cooper served in the U.S. Navy hospital corps from 1944 to 1946.

Doctor Williams is a 1950 graduate of the University of Western Ontario and interned at Methodist Hospital, Gary, Indiana. Doctor Williams practiced in Morocco, Indiana, for five years before going to the Mayo Clinic in 1956 for training in radiology. A diplomate in the American Academy of Radiology, he is certified in the radioactive isotopic field. Doctor Williams also served during World War II as a navigator and bombardier in the Royal Canadian Air Force.

Doctor Connors Accepts Hospital Post

The duties of associate pathologist and director of medical education at St. Mary's Hospital, Madison, have been assumed by *Dr. Dean M. Connors.* He had spent the last two years at the A. D. Daniels Memorial Laboratory at St. Mary's Hospital in Rhinelander.

Following service in the Army during World War II, Doctor Connors attended the University of Wisconsin, receiving his medical degree in 1952. An in-

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ternship at Abington Hospital in suburban Philadelphia preceded postgraduate work in the field of pathology at the University of Wisconsin.

Bonduel Has New Clinic

A new 17-room clinic which was started last fall in Bonduel, has been completed and is occupied by *Drs. W. W. Grover* and *Patricia Stuff*. The building, designed by Doctor Grover, is constructed with a red brick exterior and a modernistic interior. Rooms included in the sound proof clinic are: a reception room, a children's corner and adult section, business office, laboratory room, two adult examination rooms, pediatric room, an emergency room with an outside entrance, x-ray room, dark room, consultation room, EKG diathermy room, two store rooms, and utility rooms. The doctors have begun construction on their new home on the lot adjacent to the clinic.

Doctor Becker Certified

Dr. Irvin M. Becker was certified by the Subspecialty Board of Gastroenterology in April. Doctor Becker has been practicing as an internist and gastroenterologist in Milwaukee since release from the U.S. Navy in 1954.

Doctor Shutkin Receives Appointment

Dr. Michael W. Shutkin, Associate Professor of Medicine at Marquette University School of Medicine, has been appointed Chief of the Section of Gastroenterology at Milwaukee County General Hospital.

Doctor Larson Receives High Honor

One of the highest honors awarded a peace-time officer, the Commendation Ribbon with Medal Pendant, was granted Dr. Duane Larson, Madison, upon his discharge from the Army, June 29. The medal was given in recognition of his work done at Brooke Army Hospital, San Antonio, Texas, in developing a new type of dressing in the treatment of burns.

His method applies only one layer of coarse mesh gauze to the burned area which is superior to the bulky dressing now used. The process affords the patient more comfort, requires less patient care, allows skin grafting to be done easier and with more effective results, and permits more cases to be treated with a minimum amount of dressing material—important in the care of mass burn casualties. The Army is building a five-panel display on the technique and has filmed two movies to be shown to medical groups around the country.

A medical graduate of the University of Wisconsin, Doctor Larson served two years of a surgical residency there before entering the Army. He has now returned to the Wisconsin General Hospital for completion of his postgraduate work in general surgery and then plans to take three additional years in Texas training in plastic and reconstructive surgery.

What's New at the Medical Schools

Respiratory and Rehabilitation Center Opens

The formal opening of the new Respiratory and Rehabilitation Center at the University of Wisconsin Medical School was completed early in September. The unit, which is being developed in the Department of Pediatrics, is housed on the seventh floor of the University Hospitals where office space and pulmonary research laboratories, as well as occupational and physical therapy functions will be available. This Respiratory and Rehabilitation Center is the first of its kind in Wisconsin and will also accept patients from Iowa, Minnesota, and parts of South Dakota. It will serve as the focus for a broad program in rehabilitation, as well as a research opportunity in pulmonary physiology and neuro-muscular physiology.

The program, under the direction of Dr. Arthur A. Siebens and the Department of Pediatrics, is a collaborative enterprise with Medicine, Orthopedics and Physical Medicine. The Center will be a joint effort by the Medical School, the College of Letters and Science, the School of Education, and the Extension Division.

Dr. Jacoby Heads Anesthesiology Division

Jay Jacoby, M.D., Professor and Director of Anesthesia at Ohio State University, has accepted an appointment at Marquette University School of Medicine as Professor and Head of the Division of Anesthesiology. The appointment became effective August 1.

Doctor Jacoby, 42, will be a full-time anesthesiologist at the medical school and the Milwaukee County Hospital. His duties will be concerned with establishing a training program in anesthesiology for medical students and residents at Milwaukee County Hospital with David H. Gatherum, M.D., present staff anesthesiologist at the hospital and an Instructor in Anesthesiology at the medical school. By July, 1960, at least eight residencies in anesthesia will be available at Milwaukee County Hospital. Doctor Jacoby will work with Sherwood W. Gorens, M.D., Chief of Anesthesia at the Veterans Administration Hospital, Wood, and an Instructor in Anesthesiology at the medical school, in expanding the already existing program at Wood. Doctor Jacoby will serve as a Consultant in Anesthesia.

Dr. Edwin H. Ellison, in announcing the appointment, stated that Doctor Jacoby is one of the recognized authorities on graduate training in this important surgical specialty. Since 1955 he has been an Examiner for the American Board of Anesthesiology. In 1954 senior medical students at Ohio State elected him "Man of the Year" for his abilities as an outstanding teacher.

Much of Doctor Jacoby's scientific writing has been in the field of emergency resuscitation. In 1954 he published an article on transtracheal artificial respiration in which a method was described for insertion of a needle in the trachea instead of performing an emergency tracheotomy. Due to be published this year is a textbook entitled, "Introduction to Anesthesia." Doctor Jacoby also has served as the editor of *Anesthesia Abstracts*, a scientific periodical.

Doctor Jacoby received both his B.S. and M.D. degrees from the University of Minnesota in 1939 and 1941, respectively. His internship was served at Kings County Hospital, Brooklyn, from 1941–42. From 1942–45 he was a Captain in the United States Army Medical Corps. In 1946 he became a Research Associate at the University of Chicago, receiving his Ph.D. in Pharmacology from that University in 1947. At the same time he was a resident in anesthesiology at Billings Hospital, Chicago.

In 1947 Doctor Jacoby accepted an appointment at Ohio State University as an Associate Professor and Director of the Department of Anesthesia. In 1950 he became a Professor and Director of the Department.

Three Faculty Members Receive Emeritus Appointments

The members of the faculty of Marquette's School of Medicine who retired this year have received emeritus appointments to the faculty. They are F. Herbert Haessler, M.D., Professor of Ophthalmology, Emeritus; Edward F. Barta, M.D., Professor of Pathology, Emeritus; and Karl E. Kassowitz, M.D., Clinical Professor of Pediatrics, Emeritus.

Two Appointments Made in Basic Science Departments

Two new faculty appointments, one in the department of physiology, the other in the department of microbiology and immunology have been made in the basic science departments of Marquette University School of Medicine. Loyd W. Tiffany, Ph.D., has been appointed an Instructor in Microbiology and Immunology, effective August 1. Robert W. Rasch, M.D., Ph.D. has been appointed an Instructor in Physiology, effective September 1.

Curative Workshop and Marquette Form Affiliation

The Curative Workshop of Milwaukee, Inc. has entered into an affiliation with Marquette University which will integrate areas of professional training, research, and patient services in which both are mutually interested. The announcement, effective July 1, was made jointly by T. S. Allegrezza, Execu-

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avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4, 5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2, 4, 5] This is reported to be particularly true in patients with peptic ulcer.[4]

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage

Regular aspirin crystals 24 hours after being mixed into water.

Calurin crystals in solution one minute after being mixed into water.

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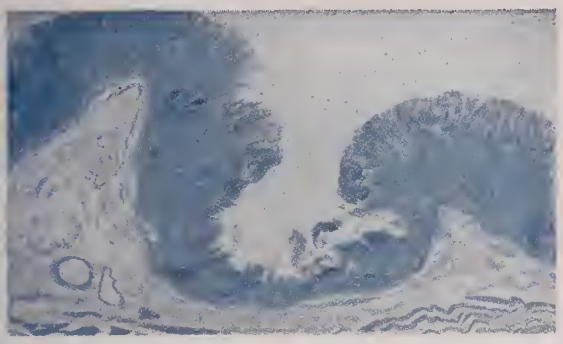
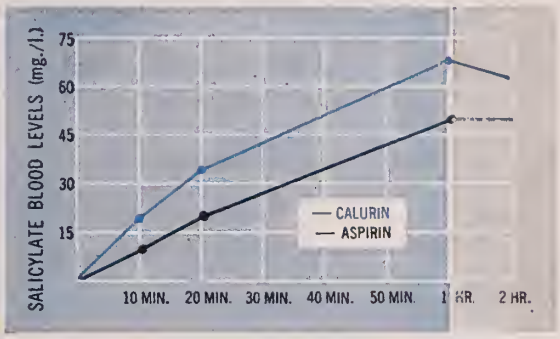


Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

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*TRADEMARK

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tive Director of the Curative Workshop, and the Very Rev. E. J. O'Donnell, S.J., President of the University.

John S. Hirschboeck, M.D., Dean of the medical school, said that such an affiliation would provide a broad range of educational facilities for students in medicine or allied fields of rehabilitation. It would also provide joint research facilities and an interchange of staff and facilities in the two institutions, as well as effect a comprehensive program of rehabilitation services for disabled patients.

While the University and Workshop will be affiliated in projects concerning the education, research, and community service aspect, both institutions will continue their separate and independent existence, control, and management. The selection and employment of professional staff in any programs or projects in which both are engaged, however, will be by mutual agreement of both parties. The University may appoint qualified staff members of the Workshop to academic positions within the University.

George Hellmuth, M.D., Associate Professor of Occupational and Environmental Medicine, has been appointed the representative of the School of Medicine in carrying out the terms of the agreement.

Dr. D. Murray Angevine Honored

The American Cancer Society has announced the appointment of Dr. D. Murray Angevine, Chairman and Professor of the Department of Pathology, UW Medical School, as Chairman of the Advisory Committee on Research on the Pathogenesis of Cancer for the period of September 1, 1959 to August 30, 1960.

Additional Faculty at UW

Additional faculty appointments at the University of Wisconsin Medical School have recently been announced.

Robert I. DeMars has accepted a position as Assistant Professor in the Department of Medical Genetics, effective July 1. Doctor DeMars, who received a B.S. degree in 1949 from City College of New York and a Ph.D. degree in Bacteriology from the University of Illinois in 1953, was with the National Institutes of Health, Bethesda, Maryland, prior to coming to the University of Wisconsin. In addition to his teaching responsibilities he will do research work in the genetics of human cells and grown-in tissue culture.

David B. Slautterback has accepted a position as Assistant Professor in the Anatomy Department effective July 1. He received both a B.S. degree and a M.S. degree in Zoology at the University of Michigan and a Ph.D. degree in Anatomy at the Sloan–Kettering Division of Cornell University in 1952. His previous employment includes teaching and research at New York University Medical College and Cornell University Medical College. Professor Slautterback will teach Histology and Gross Anatomy and do research in cell fine structure.

Thomas B. Litherland joined the staff of the Child Psychiatry Clinic as Chief Psychiatric Social Worker June 22. Mr. Litherland is a graduate of the University of Illinois School of Social Work and has both an A.B. and a M.S.W. degree from there. Prior to joining the staff of the University of Wisconsin Medical Center he was Chief Psychiatric Social Worker at the Kansas Treatment Center for Children at Topeka, Kansas.

A former intern and resident at University Hospitals, Stanley I. Inhorn, has joined the staff of the University Medical School as an Instructor in Preventive Medicine and Pathology and Assistant Pathologist at the State Laboratory of Hygiene. He is a 1949 graduate of Western Reserve University and completed his medical training at Columbia University in 1953. He joined the staff in September.

Dr. Gabriele Zu Rhein has been appointed Assistant Professor of Neurology in the Department of Neurology, thus making this a joint appointment with the Department of Pathology.

John Withall, Ph.D., since 1956 executive director of the U. S. Educational Foundation in Pakistan, has assumed new duties at the University of Wisconsin as director of a quarter of a million dollar mental health program, Dean Lindley J. Stiles of the UW School of Education announced recently.

Born in London, England, Professor Withall has a B.A. and M.Ed. from Bishop's University, Quebec, Canada, and a Ph.D. from the University of Chicago.

Withall has previously served on the faculty of the University of Chicago, Brooklyn College, the University of Delaware, and with the National Education Assoc. He has done pioneer research in the measurement of classroom climate and in the area of teacher-learner interaction.

Funds for the program he will head were made available to the University last year by the National Institutes of Health of the U. S. Public Health Service for a "pilot and evaluation project" consisting of a study of teacher education as related to student mental health.

A total of $54,676 was granted for the period July 1, 1959, to June 30, 1960, with $221,036 recommended as support through 1962.

According to Professor Withall, the study will consist of testing various approaches in teacher education in order to find the best possible method of developing greater mental health in students.

Research will be under the supervision of an advisory committee with an executive group composed of Dr. Carl R. Rogers, departments of psychology and psychiatry, as chairman, and Professors John W. M. Rothney and Virgil E. Herrick of the School of Education.

Work Classification Unit Expanded

An expanded community service project designed to render supplementary rehabilitation services to cardiac patients was made available at Marquette University School of Medicine and the Curative Work-

(continued)

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1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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shop of Milwaukee, Inc. beginning August 14. The project, known as the Work Classification Unit (WCU) has previously been conducted as a pilot project of the Wisconsin Heart Association and Marquette at the Milwaukee County Hospital. The new unit will be under the supervision of the Professor and Chairman of the Department of Occupational and Environmental Medicine, Elston L. Belknap, M.D.

"The purpose of WCU is to evaluate cardiac patients from the standpoint of the amount and type of work they can safely perform," said George A. Hellmuth, M.D., Associate Professor of Occupational and Environmental Medicine, who will head the Unit. Doctor Hellmuth pointed out that the two-year pilot study of WCU had proved to be of value, and expanded facilities were now necessary.

The Work Classification Unit utilizes the team approach to return a cardiac patient to a useful place in society. Working with the physician are a psychologist, vocational counselor, and a medical social worker who not only evaluate and educate patients with heart disease but also their family and the community at large. There are about 40 such units in the country.

The re-located WCU will be a joint project of the Wisconsin Heart Association, Marquette University School of Medicine, Curative Workshop of Milwaukee, Inc., and the State Board of Vocational and Adult Education Rehabilitation Division.

"WCU will be a valuable aid to business and industry to determine the amount and type of work a cardiac employee can safely perform," Doctor Hellmuth said. "This is done in cooperation with and upon the referral of the patient's family physician or an industrial physician. Precise determinations of physical fitness and work prescriptions are the primary function of the Unit. This is achieved through the use of a multi-discipline team approach toward total rehabilitation."

Doctor Hellmuth stated that it was the experience of this Unit, during the pilot study of 108 cardiac patients, that a significant number not working at the time of the initial visit, were returned to work following evaluation.

WCU is open to all Wisconsin residents upon referral by a physician. Although a fee will be charged to cover costs, no patient will be refused because of inability to pay. Physicians wishing to contact the Unit may write to Dr. George A. Hellmuth at Marquette University School of Medicine.

Four to Participate in College of Surgeons Program

Participating in the American College of Surgeons Annual Clinical Congress at Atlantic City September 28–October 2 are four faculty members from Marquette.

William H. Frackleton, M.D., Clinical Professor and Head of the Division of Plastic and Reconstructive Surgery, will participate in a panel on "Delayed Union and Nonunion of Fractures of the Long Bones" on October 2. Edwin H. Ellison, M.D., Professor and Chairman of the Department of Surgery, will be a panel member on a TV program on "Sphincterotomy" on September 29.

Participating in postgraduate courses are Walter P. Blount, M.D. Professor and Head of the Division of Orthopedic Surgery; Bruce J. Brewer, M.D., Associate Clinical Professor of Orthopedic Surgery; and Doctor Ellison.

On September 29 Doctor Blount will participate in a course entitled "Internal Fixation and Operative Treatment of Fractures." Doctor Blount will discuss "Operative Reduction and Internal Fixation of Fractures in Children."

Doctor Brewer will participate in a course on September 30 and October 1 on "Athletic Injuries." On September 30 he will discuss "Tendon Injuries in Sports: Mechanism, Diagnosis, and Treatment." On October 1 he will discuss "Treatment of Fresh Cartilage and Ligamentous Injuries of the Knee."

On September 29 Doctor Ellison will participate in a course on "The Surgical Treatment of Acid-peptic Disease." He will discuss "Ideal Ulcer Operation in the Light of Current Knowledge of Gastric Physiology" and "Vagectomy with Hemigastrectomy or with Antrectomy, Current Status."

Milwaukee County Hospital Host at Meeting

Milwaukee County Hospital was host at a meeting of the Chicago Blood Group on September 16 in the Fifth Floor Conference Room of the hospital. The following program was arranged by Anthony V. Pisciotta, M.D., program chairman:

Hypogammaglobulinemia and auto-immune hemolytic anemia in chronic lymphocytic leukemia
Anthony V. Pisciotta, M D., Louis F. Jermain, M.D., and Jean Hinz, A.B.

Thiol groups in intact erythrocytes
Samuel A. Morell, Ph.D., V. E. Ayers, M.S., and T. J. Greenwalt, M.D.

The possible relationship of the clotting agent in erythrocytes to coagulation
A. J. Quick, M.D., Ph.D., and C. V. Hussey, M.S.

Biochemical studies in leukocytes of patients susceptible to agranulocytosis
Anthony V. Pisciotta, M.D., S. A. Ebbe, M.D., Mary Daly, B.S., and Joseph Gutierrez, A.B.

Seventeen Grants Awarded Marquette

A total of $88,836 has been received by Marquette University School of Medicine from the Wisconsin Heart Association for 17 grants for the period July 1, 1959, to June 30, 1960.

Projects and investigators are as follows: James G. Hilton, Ph.D., Associate Professor of Pharmacology, "Study of the effects of cholinesterase inhibitors, adrenergic blocking agents, and ganglionic blocking agents in hypotension induced by total spinal anesthesia or epinephrine shock;" Albert C.

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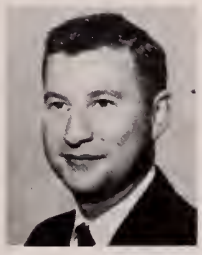

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Yard, Ph.D., Instructor in Pharmacology, "Role of prolonged vasoconstriction in the etiology of shock;" James J. Smith, M.D., Ph.D., Professor and Chairman of the Department of Physiology, and William J. Stekiel, Ph.D., Research Associate in Physiology, "A study of the single shot clearance method for the estimation of liver blood flow;" Howard M. Klitgaard, Ph.D., Assistant Professor of Physiology, "Comparative study of the enzyme changes in cardiac and skeletal muscle in altered metabolic states."

Francios M. Abboud, M.D., Research Associate in Cardiology in the Department of Medicine, "An investigation of the arterial wall elasticity;" John H. Huston, M.D., Assistant Professor of Medicine, "Myocardial oxygen metabolism in the aged;" Lyle H. Hamilton, Ph.D., Assistant Professor of Physiology and Ross C. Kory, M.D., Associate Professor of Medicine, "A study of regional blood flow and blood volume in the pulmonary circulation;" Marvin Glicklich, M.D., Clinical Instructor in Surgery, "Studies in small vessel anastamoses;" Edwin H. Ellison, M.D., Professor and Chairman of the Department of Surgery, "Studies on the diagnosis and prevention of thromboembolic diseases in the surgical patient."

Thomas Wall, M.D., Instructor in Surgery, and Edwin H. Ellison, M.D., "A study of the role of the status of the cardiovascular system in the etiology of staphylococcus enterocolitis and its relationship to irreversible shock in the dog;" A. Stephen Close, M.D., Assistant Professor of Surgery, "Brain metabolism and pathology during complete cardiopulmonary by-pass using a bubble-type oxygenator;" Paul F. Hausmann, M.D., Assistant Clinical Professor of Surgery, "The use of fascia lata grafts for the enlargement of the right heart outflow tract;" A. Stephen Close, M.D., "A comparison of the electrocardiographic and pathologic effects of norepinephrine and mephentermine sulfate (Wyamine) in the treatment of experimental hemorrhagic hypotension;" Donald A. Roth, M.D., Ph.D., Instructor in Medicine, "The evaluation of decreased extracellular fluid volume as a factor in failure of diuresis;" Robert W. Ewer, M.D., Instructor in Medicine, "To delineate the mechanism of increased excretion of noradrenaline-like substances in patients with advanced disease of the liver."

James J. Smith, M.D., Ph.D., "Fellowships in physiology under the direction of Doctor Smith;" Victor M. Bernhard, M.D., Clinical Instructor in Surgery, "The effect of atherogenesis on the endarterectomized aorta of the dog."

Two Training Grants Received

The Department of Medicine of Marquette University School of Medicine has received two training grants totalling $16,973 from the United States Public Health Service. The grants run for a period of one year beginning July 1. One is a training grant in diabetes under the direction of William W. Engstrom, M.D., the Francis D. Murphy Professor and Chairman of the Department of Medicine; the other is a training grant in hematology under the direction of Anthony V. Pisciotta, M.D., Associate Professor of Medicine.

Company Donates $10,000 for Cancer Research

Marquette University School of Medicine has received a $10,000 contribution for cancer research from the Joseph Schlitz Brewing Company of Milwaukee. The contribution was made in memory of Robert A. Uihlein, late vice-president and secretary of the brewing company, who died of this disease.

In making the grant, Erwin C. Uihlein, president of the company, said his late brother had an admiration for the research done at Marquette. He stated, "The tremendous impact of this disease has been keenly felt in our organization through the loss of our beloved vice-president and secretary, and we ask that this contribution be accepted as a memorial to him."

Grant on Rehabilitation Renewed by National Foundation

A renewal grant of $85,688 for a period of two years beginning July 1 has been received from the National Foundation for a study of rehabilitation and how best to train medical students to meet the fast changing patterns of disease. Marquette University School of Medicine is one of 14 medical schools selected for this pilot study. Harold E. Cook, M.D., Associate in Medicine, and Director of Medical Services at Milwaukee County Institutions, is in charge of the study. It will be conducted at the Milwaukee County Hospital.

Winner of John Scott Award

Prof. Karl P. Link, department of biochemistry, UW, has been selected as a winner of the 1959 John Scott Awards for useful inventions for the benefit of mankind, according to an announcement by the Board of Directors of City Trusts, Philadelphia, Pa. He was one of four winners. His selection was for his invention of "Dicumarol" and of the method of extraction. The award consists of a copper medal, a scroll bearing the citation, and a cash prize of $1,000.

Obituaries

Dr. K. W. Baker, Turtle Lake, died April 9 at the age of 81.

Doctor Baker was born at Wisconsin Rapids in 1878 and graduated from Physicians and Surgeons College of Milwaukee in 1900. During his many years in the medical profession, he practiced at Greenwood, Wisconsin Rapids, Owen, Tony, Eau Claire, Rib Lake, Glidden, and located at Turtle Lake in 1946.

Surviving are his widow, LaVerne, six daughters and three sons.

Dr. A. M. Blake, 95, died April 19 following a short illness. One of the oldest practicing physicians in the nation, he had conducted an office at Waunakee for more than 70 years.

He was born in Vermont in 1864. Prior to establishing his Waunakee practice, Doctor Blake graduated from Cincinnati Medical School in 1887 and was located at Lodi for one year. In 1947 the Waunakee Civic Club sponsored a "Doc Blake Day" which was attended by thousands of people in the area paying tribute to his 60th anniversary in practice there.

An enthusiastic hobbyist and sportsman, Doctor Blake did wood working, gardening, photography, boat building, had managed the old Westport baseball club and enjoyed fishing. He was also a founder and director of the Waunakee State Bank.

Surviving are a daughter, a son, three grandchildren and nine great-grandchildren.

Dr. L. B. McBain, 53, died May 2 at his Appleton home.

Doctor McBain was born at Grand Rapids, Michigan, in 1905. He received a medical degree from the University of Wisconsin in 1930, interned at the Kansas City Bell Memorial Hospital for one year, and from 1931 to 1933 took residency training at the Oklahoma University Hospital. Except for five years served in the U. S. Army Medical Corps during World War II, Doctor McBain had spent his entire professional career practicing in Appleton. He established a partnership with Dr. J. W. Laird in 1949.

He was a member of the Outagamie County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Association of General Practitioners.

Surviving are his widow and two daughters, both university students.

Dr. J. D. Warrick of Camarillo, California, who had practiced in Wisconsin for 17 years, passed away May 4 while on an eastern trip. After receiving a fellowship by the American Psychiatric Association at Philadelphia, he had traveled to New York for a vacation when he was stricken. He was 63 years of age.

Born in Alabama in 1895, he received his medical education at the Chicago College of Medicine and Surgery and postgraduate training in psychiatry in Boston, Massachusetts, and in obstetrics and surgery at Cook County Hospital, Chicago, Illinois. In 1931 he settled in Walworth County, leaving in 1948 to assume the post of head of staff at the California State Hospital at Camarillo. He had spent ten years of his Wisconsin medical practice at Sharon.

At the time of his death, Doctor Warrick was a member of the Ventura County Medical Society, the California Medical Association, and the American Medical Association. He had previously held memberships with the Walworth County Medical Society and the State Medical Society of Wisconsin.

Surviving are his widow, Helen; a daughter and two sons.

Dr. A. P. Feider, 39, died unexpectedly May 9. He had been a general practitioner in Cleveland since 1947.

A Wisconsin native, born in Belgium in 1919, Doctor Feider obtained his medical education at Marquette University. Upon graduation in 1944 he entered the U. S. Navy for four years, taking an internship at St. Joseph's and St. Michael's Hospital, Milwaukee, and a residency at Milford Memorial Hospital at Milford, Delaware. He was a medical examiner for numerous insurance companies and on the staffs of St. Nicholas and Sheboygan Memorial Hospitals, Sheboygan, and Holy Family and Memorial Hospitals, Manitowoc.

Doctor Feider was a member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice.

Survivors include his widow, Lucille, and five children, Phyllis, Robert, Dennis, Carol and Bruce.

Dr. S. S. Salinko, Milwaukee, passed away May 19 after an extended illness. He was 88 years of age.

A native of Poland, having been born at Grodno in 1870, Doctor Salinko graduated from the Warsaw Medical College in 1893 and came to the United States following three years of practice in Warsaw. He was graduated as a physician from the Maryland Medical College in 1901 and licensed in Wisconsin in 1902. Doctor Salinko practiced in Milwaukee as an internist and was a former U. S. Veteran Pension examiner. In 1941 he took a postgraduate course in endocrinology at the New York Postgraduate Hospital. Illness forced his retirement in 1953. The doctor was a veteran of both the Spanish-American War and World War I.

He held memberships in the State Medical Society of Wisconsin and the American Medical Association, and was a Fifty Year member of The Medical Society of Milwaukee County.

(continued)

Survivors include his widow, Monica, two brothers and a sister.

Dr. O. W. Saunders, a retired Green Bay physician, died June 12 at the age of 63.

Doctor Saunders was born at Oconto Falls in 1896. A 1921 graduate of Rush Medical College, he had practiced his entire life in Green Bay aside from time served in the U. S. Army in World Wars I and II. Ill health forced him into retirement four years ago.

During his professional career, Doctor Saunders was secretary to the staff at Bellin Hospital, was on the medical staff of St. Mary's Hospital, was a former physician for the Green Bay Packers, and had held the position of city health officer.

Memberships held by the doctor included the Brown County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of General Practice. He served as president-elect of his county society in 1942 and as president in 1947. He was also delegate to the State Society for six years, on the Legislative and Public Health Committee, and chairman of both the Grievance and Fee Schedule Committees.

He is survived by his widow, Gladys, and a daughter.

Dr. Matthew W. Monroe, a Milwaukee internist, died at his home June 14. He was 40 years of age.

He was born at Dunkirk, New York, in 1919 and graduated from Marquette University School of Medicine in 1944. Prior to opening his Milwaukee office, Doctor Monroe interned at St. Mary's Hospital, Milwaukee, served two years in the U. S. Army, and from 1947 to 1950 took a residency at the Veterans Administration Hospital at Wood. He was a clinical instructor of internal medicine at Marquette University and on the staff of two Milwaukee hospitals, St. Mary's and St. Michael's.

Professional memberships held by Doctor Monroe included those with The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the Milwaukee Academy of Medicine, and the American Board of Internal Medicine.

Besides his widow, Susan, two sons, Matthew, Jr., and Mark, and a daughter, Jaime, survive.

Dr. B. M. Rinehart, Ogema, passed away June 17 at the age of 85.

Born at Conrad, Iowa, in 1874, Doctor Rinehart graduated from the Hahnemann Medical School in 1901 and the Chicago Eye, Ear, Nose and Throat College in 1908. His first twenty years of practice were spent in Moline, Illinois, where he was on the staff of the Moline City Hospital and Nurses teaching staff. Doctor Rinehart then was located in Stevens Point for two years before moving to Ogema in 1934. Until 1930 the doctor had practiced exclusively in his specialty, but since that time had engaged in a general practice which he maintained until June 1 despite ill health during the past seven months.

Doctor Rinehart held memberships in the Price-Taylor County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Ruby; three sons and five daughters.

Dr. H. C. Wiger, 78, died June 17. He was a retired Barron county physician.

Doctor Wiger was born at Mabel, Minnesota, in 1880, graduated from Marquette University School of Medicine in 1915, served in the armed forces during World War I, and practiced at Dallas until 1924. He then located at Barron, moving to Rice Lake in 1927. The doctor entered retirement in 1946 and in October of 1957 the residents of Rice Lake honored him at an "Appreciation Night" at the local high school.

Besides his widow, Agnes, a daughter and two sons survive.

Dr. R. A. Hulse, 47, a former resident of Fond du Lac and a practicing physician in Burlington, Iowa, died June 29 as a result of injuries incurred in an automobile accident.

Born in 1912, Doctor Hulse graduated from the University of Louisville in 1939. He interned at Charity Hospital, New Orleans, Louisiana, served one year of a surgery residency at Louisville City Hospital and another year of gynecology residency in New York. He saw military service from 1943 to 1946.

Surviving are two daughters and a sister.

Dr. L. V. Littig, 62, died unexpectedly at his Madison home July 6.

A resident of Iowa until coming to Madison in 1921, Doctor Littig was born at Davenport in 1896 and completed his medical education at the University of Iowa in 1921. He interned at Madison General Hospital and did postgraduate work at the University of Wisconsin. Doctor Littig became a radiologist at Madison General in 1925, leaving in 1949 to open a private practice in Madison. He was also radiologist at the Quisling Clinic in Madison, and had formerly been radiologist at the St. Mary's Ringling Hospital in Baraboo, the Fort Atkinson Memorial Hospital, the Dells Clinic in Wisconsin Dells, and the Reedsburg Municipal Hospital. Doctor Littig was one of the organizers and past treasurer of Wisconsin Physicians Service.

A member of the State Medical Society of Wisconsin, the Dane County Medical Society, the American Medical Association, the Radiological Society of North America, and the American College of Radiology, he was also certified by the American Board of Radiology. He was first president and charter member of the Wisconsin Radiological Society.

Besides his widow, Sally, two sons, Lawrence W., Ann Arbor, Michigan, and Norman P., at home, survive.

(continued)

OBITUARIES (continued)

Dr. Justus Sutherland, a retired Oshkosh eye, ear, nose and throat specialist, died July 26 following a lingering illness. He was 83 years of age.

Born at Sylvester in 1875, Doctor Sutherland was a 1900 graduate of Marquette University School of Medicine. He practiced at Brodhead before locating in Oshkosh, in 1923, where he was active until retirement in 1956. Doctor Sutherland served with the Army Medical Corps in World War I, being stationed overseas, and was a staff member at the Veterans Administration Hospital, Wood, in World War II.

Immediate survivors include his widow, Bessie, and two daughters.

Dr. B. O. Fosse, a physician in Beloit for 50 years, died at his home August 2. He was 80 years of age.

Doctor Fosse was born at Newark, Illinois, in 1878. He obtained a Bachelor's degree from Beloit College in 1901 and graduated from Northwestern Medical School in 1904. He did postgraduate work at the Mayo Clinic and at the Crile Clinic in Cleveland, Ohio. Between 1908 and 1912 Doctor Fosse was located at Woodford and spent the remaining years of his practice at Beloit. He retired in the late 1940's.

He was chairman for six of the eleven years he served on the Beloit fire and police commission and was also a former Beloit High School Athletic Association physician. During World War I he held the rank of major in the Army Medical Corps, being stationed at the American Hospital at LeMans, France.

Memberships held by him included those with the State Medical Society of Wisconsin, the State Society's Fifty Year Club, the Rock County Medical Society, and the American Medical Association. He had served as president of his county society and, also, as president of the Beloit Physicians Club.

He is survived by his widow, May, two sons and two daughters.

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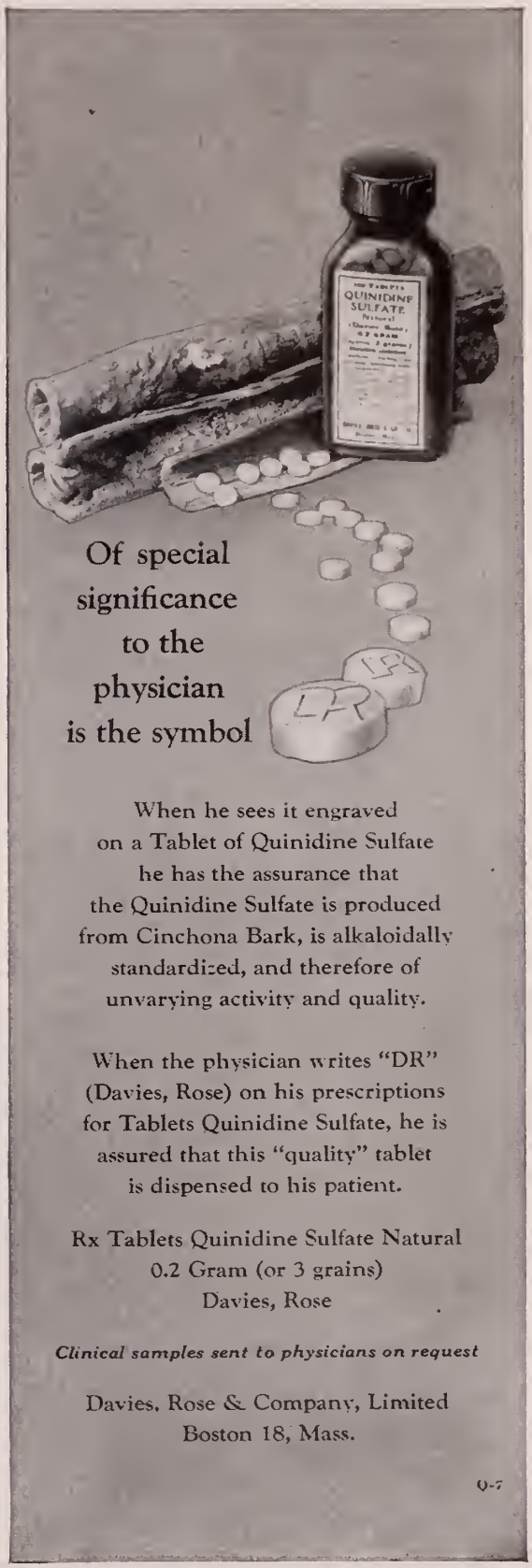

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Medical Meetings - Postgraduate Courses

Athletic Injuries Clinic

Because of its popularity and enthusiasm of physicians and school athletic personnel, a second Athletic Injuries Clinic has been scheduled this year on October 8 at Memorial High School in Eau Claire. Under the sponsorship of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, the Clinic is being presented with the generous support of the Benson Optical Company, Eau Claire; Hurley X-Ray Company, Eau Claire; E. M. Hale and Company, Eau Claire; Northwestern Wisconsin Education Association; and Wisconsin Interscholastic Athletic Association.

The following program has been arranged:

1:30–2:30 *Conditioning and Safety*
C. M. Ihle, M.D., Eau Claire
Robert J. Francis, Professor of Physical Education for Men, UW, Madison
Ed. Reutinger, Director of School and College Sales, Wilson Sporting Goods Company, River Grove, Illinois

2:30–3:00 *Diagnosis and Treatment of Head and Abdominal Injuries "On The Field"*
Anthony R. Curreri, M.D., Professor of Surgery, UW, Madison

3:00–3:30 *Common Injuries of the Legs and How to Care for Them*
F. W. Reichardt, M.D., Stevens Point

3:30–4:00 *What Regulations are Needed in Athletic Programs*
L. M. Simonson, M.D., Sheboygan, Chairman of the Division on School Health of SMS (moderator)
James C. H. Russell, M.D., Fort Atkinson
Jack Tetzner, Athletic Director, Thorp High School
William Terrill, Superintendent, Menomonie High School

Application has been made to the American Academy of General Practice for Category II credit.

Workshop on Rehabilitating Crippled

The part played by the social worker in rehabilitating the crippled will be defined and strengthened in an unusual workshop to be held in Chicago in June, 1960.

The workshop will be conducted jointly by the National Society for Crippled Children and Adults and the University of Chicago, School of Social Service Administration, financed by a $13,610 grant by the Federal Office of Vocational Rehabilitation. The grant will make possible 40 all-expense traineeships for social workers presently employed in rehabilitation programs throughout the United States.

Additional information is available from Oscar Kurren, National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12, Ill.

Final Plans on Cancer Symposium

Final plans have been made by Dr. Robert Samp, coordinator, for the fifth annual fall cancer symposium at the UW Medical Center Saturday, October 24, Madison. Since almost half of the reservations have been filled already, Doctor Samp urges those who plan to attend to make reservations now.

There will be two panels of speakers composed of faculty from the Cancer Research Hospital, a division of the University Hospitals. These panels will concentrate their efforts in two discussions: cancer chemotherapy and what's new, and basic human cancer research. Dr. Fred Ansfield will chairman the chemotherapy discussion while Dr. James M. Price will chairman the research portion.

Dr. Anthony Curreri will moderate the program which in addition to the above two panels will feature a report on the establishment and progress of county tumor registries with a presentation by Dr. Norman Becker of Fond du Lac.

Guest lecturer will be Dr. Lauren Ackerman, pathologist, of St. Louis, Mo. The program will be held from 9:00 a.m. to 12:00 noon. Following lunch, participants will attend the Wisconsin–Ohio State football game in the afternoon.

The symposium is a combined meeting with the Wisconsin Cancer Society and the Cancer Research Department of Surgery of the University of Wisconsin Medical School, and again this year joined by the Wisconsin Alumni Association.

Marquette–Jackson Clinic Program

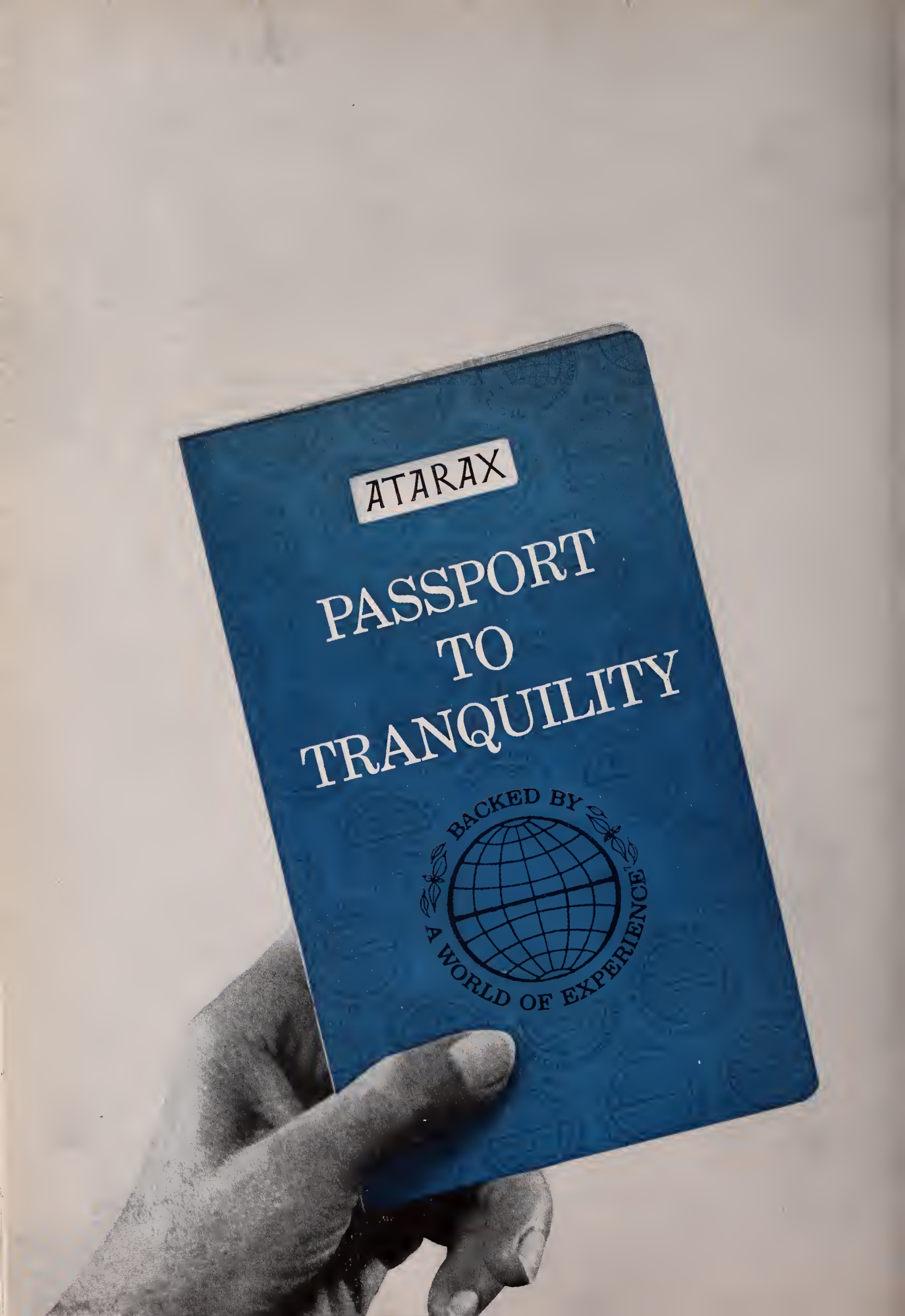
The twenty-ninth Marquette-Jackson Clinic postgraduate program will be held in Madison on Saturday morning, October 3. The following program has been scheduled:

8:30 REGISTRATION
Tower of Health, Methodist Hospital

8:40 *Cytological Diagnosis of Cervical Disease*
Robert E. Wheatley, M.D.

9:00 *Nephrolithiasis*
George H. Ewell, M.D.

(continued)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References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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WISCONSIN CALENDAR COMING EVENTS

1959

Oct. 1–3: Postgraduate course for GPs, UW Medical Center, Madison.

Oct. 7 & 14: Clinical review course for AAGP members, Mount Sinai Hospital, Milwaukee.

Oct. 8 & 15: Clinical review course for AAGP members, Mount Sinai Hospital, Milwaukee.

Oct. 8: SMS Foundation Athletic Injuries Clinic, Memorial High School, Eau Claire.

Oct. 13: Circuit Teaching Program, St. Vincent's Hospital, Green Bay.

Oct. 14: Circuit teaching program, Elks Club, Ashland.

Oct. 15: Circuit teaching program, Mead Hotel, Wisconsin Rapids.

Oct. 22–24: Postgraduate course in allergy for GP, UW Medical Center, Madison.

Oct. 24: Fall cancer symposium, UW Medical Center, Madison.

1960

Jan. 19: Circuit teaching program, Vernon County Memorial Hospital, Viroqua.

Jan. 20: Circuit teaching program, Waupun Memorial Hospital, Waupun.

Jan. 21: Circuit teaching program, Elks Club, Appleton.

Feb. 18: Postgraduate course in therapeutics, UW Medical Center, Madison.

Mar. 10–12: Postgraduate course in neurological problems, UW Medical Center, Madison.

Apr. 7–9: Postgraduate course in endocrinology in pediatrics, UW Medical Center, Madison.

May 3–5: SMS annual meeting, Milwaukee.

May 19–20: Postgraduate course in health aspects of air pollution, UW Medical Center, Madison.

June 23: Teaching program on the heart and lung, for AAGP members, other interested physicans, Madison.

Note: Wisconsin specialty groups, medical schools, hospitals, and paramedical associations are invited to submit a list of their forthcoming meetings or courses for this calendar. Deadline for copy is first of month prior to month of publication. Address communications to: Wisconsin Medical Journal, Box 1109, Madison 1, Wisconsin.

MEDICAL MEETINGS (continued)

9:20 *Panel: Prevention and Management of Complications of Abdominal Surgery*
Arnold S. Jackson, M.D., Moderator, Luther E. Holmgren, M.D., John R. Steeper, M.D., William B. Parsons, M.D., William L. Waskow, M.D.

10:00 *The Half-Treated Ear*
Theodore L. Hartridge, M.D.

10:20 Intermission

10:30 *Agranulocytosis and Other Hematologic Drug Reactions*
Anthony V. Pisciotta, M.D., Associate Professor of Medicine, Marquette University School of Medicine

11:00 *Medical Management of Arterial Hyptertension*
Mischa J. Lustok, M.D., Assistant Clinical Professor of Medicine, Marquette University School of Medicine

11:30 *Cutaneous Manifestations of Internal Disease*
Donald M. Rush, M.D., Assistant Clinical Professor of Dermatology, Marquette University School of Medicine

12:00 LUNCHEON
Crystal Ballroom, Loraine Hotel

1:30 MARQUETTE-WISCONSIN FOOTBALL GAME
Camp Randall Stadium

Psychosomatic Medicine Meeting

The Academy of Psychosomatic Medicine will hold its annual meeting at the Hotel Sheraton-Cleveland in Cleveland on October 15–17, 1959. The meeting has been specifically planned for the psychosomatic orientation of the general practitioner, internist, pediatrician, obstetrician, and other nonpsychiatric physicians. There will be five symposia—with 4 speakers in each symposium—on Psychopharmacology, Anxiety, Mental Drug Therapy, Psychotherapy for the Nonpsychiatrist, and Depression. Panel discussions are scheduled on the psychosomatic aspects of gastrointestinal, arthritis-neuromuscular, and cardiovascular diseases; obesity, obstetrics-gynecology, alcoholism, geriatrics, headaches—migraine, pediatrics, hypnosis, allergy, pre- and postoperative care, and malignancy. There will be 2 panels on "The Newer Anti-Depressive Drugs."

Members of The American Academy of General Practice attending will receive one hour of category II credit for each hour in attendance. Added features are breakfasts and luncheons, a dinner-dance with entertainment, and daily tours and social events for doctors' wives. All interested physicians are invited. For further information address inquiries to: Zale A. Yanof, M. D., Program Chairman, Academy of Psychosomatic Medicine, 2282 Ashland Avenue, Toledo 10, Ohio.

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References:

1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

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Michigan Association of Blood Banks

The fifth annual meeting of the Michigan Association of Blood Banks will be held October 10 at the David Whitney House, headquarters of the Wayne County Medical Society, 1010 Antietam Street, Detroit 7, Michigan. The program includes noted speakers including Ralph M. Hartwell, M.D., President of the American Association of Blood Banks, New Orleans, La.; Alan Richardson Jones, M.D., Associate, The Children's Medical Center, Boston, Mass.; and William J. Kuhns, M.D., Director, Central Blood Bank of Pittsburgh, Pittsburgh, Pa.

Subjects to be discussed include: "Medicolegal Aspects of Operating a Blood Bank," "Drug Dependent Positive Coombs Test," "Quantitative Aspects of Anti-Rh Inhibition," "Some New Observations on the ABO Group System," "Blood Bank Problems Relating to Open Heart Surgical Procedures," "Studies on Survival of Platelets and Erythrocytes," "Screening of Hemorrhagic Disorders for the Small Laboratory," and "Use of Fluorescent Antibodies in the Detection of Minor Erythrocyte Populations."

Interstate Postgraduate Assembly

The 44th International Medical Assembly of the Interstate Postgraduate Medical Association will be held November 2–5 at the Palmer House in Chicago. Dr. Erwin R. Schmidt, Madison, is Secretary of the Association and is also program chairman for this meeting.

On the Board of Trustees, in addition to Doctor Schmidt, are Drs. R. G. Arveson, Frederic, and William B. Hildebrand, Menasha. Dr. Edgar S. Gordon, Madison, is one of the program consultants for the 1959 Assembly.

Wisconsin physicians who will be participating in the program include: Dr. Francis M. Forster, professor and chairman of the Department of Neurology, UW Medical School, Madison; Dr. Miles B. Smith, associate professor of surgery, MU School of Medicine, Milwaukee, and chief of the Surgical Service, VA Center, Wood; Dr. Wilson Weisel, assistant clinical professor of surgery, MU School of Medicine, Milwaukee; Dr. William W. Engstrom, professor and chairman, Department of Medicine, MU School of Medicine, Milwaukee; Dr. Manucher J. Javid, professor of neurosurgery, UW Medical School, Madison; and Dr. Ovid O. Meyer, professor of medicine, UW Medical School, Madison.

Mid-West Forum on Allergy

The Mid-West Forum on Allergy will hold its third annual meeting on October 31 and November 1 at the Sheraton-Blackstone Hotel, Chicago, Ill. This meeting of the Forum is sponsored by the Chicago Society of Allergy. For further information: Leon Unger, M.D., 185 North Wabash Avenue, Chicago 2, Illinois.

AMA Council on Foods and Nutrition

Infant feeding, with special emphasis on protein, iron, calcium and phosphorus, will be the topic of an October symposium sponsored by the American Medical Association's Council on Foods and Nutrition.

The symposium, to be Tuesday, October 27, will be held at the New York Hospital–Cornell Medical Center in New York City.

Co-sponsors are New York Hospital–Cornell Medical Center, Cornell University Graduate School of Nutrition, New York Academy of Medicine, and the Medical Society of the County of New York.

The morning session, opening at 9:30 a.m., will deal with the protein nutrition of infants. This subject was chozen, according to Philip L. White, Sc.D., secretary of the AMA council, because there is still some question about the amino acid requirements during the first two years of life. The problem will be examined, with a review of current knowledge and an exploration of those areas still undefined.

The morning session will be moderated by Dr. Samuel Z. Levine, professor of pediatrics at Cornell University Medical College and pediatrician-in-chief at the New York Hospital.

The second portion of the symposium will be presented at 8 p.m., with Dr. Robert L. Jackson, professor of pediatrics, University of Missouri, Columbia, as moderator.

Because anemia is a common problem among children, the iron requirements of infants will be outlined; and the clinical manifestations of genetic aberrations of calcium and phosphorus metabolism will be discussed.

Advance registration for the symposium may be made by writing to the Council on Foods and Nutrition, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

North Shore Hospital Lecture

The opening lecture in the Tenth Annual North Shore Hospital Lecture Series on "Office Management of Emotional Disorders" will be held at the hospital, 225 Sheridan Road in Winnetka, Illinois, on Wednesday, October 7, at 8:00 P.M.

"Diagnostic Signs and Symptoms of Emotional Disorders" will be discussed by John I. Nurnberger, M.D., Professor and Chairman, Department of Psychiatry; Director, The Institute of Psychiatric Research; Indiana University Medical School, Indianapolis.

The Commission on Education of the American Academy of General Practice continues to approve these lectures for postgraduate credit. All physicians and allied professional personnel are cordially invited to attend these public service lectures.

Other Dates to Remember

May 2–11, 1960: 35th Anniversary Congress of the Pan American Medical Association, Mexico City.

(continued)

American College of Allergists

The American College of Allergists Graduate Instructional Course and Annual Congress will be held February 28 to March 4, 1960, at The Americana Hotel, Bal Harbour, Miami Beach, Florida. For information contact: John D. Gillaspie, M.D., Treasurer, 2049 Broadway, Boulder, Colo.

American Fracture Association

The 20th annual meeting of the American Fracture Association will be held November 1, 2, 3, and 4 at the Roosevelt Hotel, New Orleans, La. A postgraduate course in fractures will be offered by Tulane University School of Medicine on Sunday, November 1. The course is acceptable for Category II credit by the American Academy of General Practice. Dr. Nathan E. Bear of Monroe, Wisconsin, is a member of the Board of Governors.

For further information contact: H. W. Wellmerling, M.D., Secretary-General, AFA, 610 Griesheim Building, Bloomington, Illinois.

Tenth Annual Civil Defense Conference

The 10th annual County Medical Societies Civil Defense Conference will be held in Chicago, November 7–8, at the Morrison Hotel.

Purpose of the conference, which is sponsored by the American Medical Association's Council on National Defense, is to inform and assist medical and health personnel for their roles in the event of a disaster.

According to Dr. Carl J. Sprunk, Detroit, conference chairman, the conferees will have an opportunity to:

—Participate in workshop sessions concerning medical preparedness to cope with disasters.
—Discuss and exchange information dealing with emergency medical services.
—Gain information on the availability of pamphlets and articles devoted to the medical and health aspects of civil defense.
—Hear outstanding speakers report on appropriate civil defense and disaster topics.

Methods employed in handling two disasters which occurred within the past year will be discussed during the two-day meeting. These include the fire in Chicago's Our Lady of the Angels' school and the tornado which struck St. Louis.

Featured speaker will be Congressman Melvin Price (D., Ill.), who is a ranking member of the Joint Congressional Committee on Atomic Energy. He will report on recent findings on the environmental and biological effects of nuclear warfare.

Additional information regarding the conference can be obtained by writing Mr. Frank W. Barton, Secretary, Council on National Defense, American Medical Association, 535 N. Dearborn, Chicago 10, Illinois.

AMA Clinical Meeting in Dallas

The American Medical Association's 13th clinical meeting December 1–4 in Dallas, Texas, will draw some 3,500 physicians.

Planned in cooperation with Dallas physicians, the meeting is designed to help the family physician meet his daily practice problems.

Among the subjects to be discussed on the scientific program are soft tissue injury; whiplash injuries of the neck; diabetes; heart murmurs in children; new laboratory procedures; new resuscitation techniques; premarital and marital counseling, and the problem child.

Dr. Hubertus Strughold, professor of space medicine at the School of Aviation Medicine, Randolph Air Force Base, Texas, will be principal speaker at the opening scientific session December 1. Doctor Strughold, often called "the father of space medicine," will discuss the role of medicine in the space age.

The winner of the AMA's Distinguished Service Award at the Atlantic City meeting—Dr. Michael E. DeBakey—will participate in a symposium on the surgical considerations of cerebrovascular insufficiency Tuesday afternoon, December 1.

A special feature of the AMA meeting will be a national conference on the medical aspects of sports, to be Monday, November 30—the day before the AMA meeting opens.

The conference, to be held under the auspices of the AMA's Committee on the Medical Aspects of Sports (formerly the Committee on Injury in Sports) will be open to athletic directors, coaches, and trainers, as well as interested physicians.

The program will cover the general areas of the physiology and pharmacology of exercise, the training and conditioning of the athlete, and the prevention and treatment of injuries.

American Public Health Association

Leading medical and public health authorities from Denmark, England, Ghana, India, Japan, the Soviet Union, Sweden and Yugoslavia will present scientific papers before 5,000 American colleagues at the 87th annual meeting of the American Public Health Association and meetings of related organizations in Convention Hall, Atlantic City, October 19–23.

Dr. Leona Baumgartner, New York City Commissioner of Health and president of the professional society, said that the theme, Public Health Is One World, has been adopted for the sessions "to stress the importance of public health as a spearhead for international cooperation."

Among organizations holding sessions during the week will be the American School Health Association, American College of Preventive Medicine, American Association of Public Health Physicians, American Industrial Hygiene Association, Industrial Medical Association, National Health Council, Joint Commission on Mental Health and Illness, and the Public Health Cancer Association of America.

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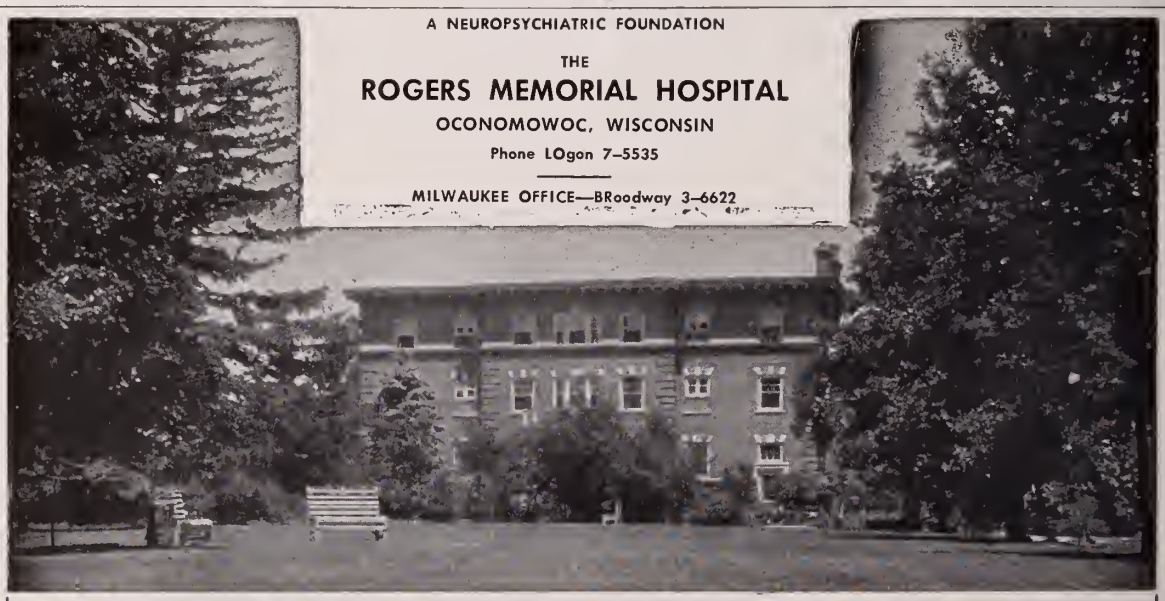

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ANNOUNCEMENTS

Examinations for Medical Officers

A Competitive Examination for appointment of physicians as Medical Officers in the Regular Corps of the United States Public Health Service Commissioned Corps will be held throughout the United States on *November 17, 18, 19, and 20, 1959.*

Appointments provide opportunities for career service in clinical medicine, research, and preventive medicine-public health. They will be made in the PHS officer grades of Assistant Surgeon and Senior Assistant Surgeon equivalent to Navy ranks of Lieutenant (j.g.) and Lieutenant, respectively.

Entrance Pay for Assistant and Senior Assistant Surgeons with dependents is nearly $8,000 a year (Assistant Surgeon applicants are assigned the temporary grade of Senior Assistant). *Promotions* are made at rapid intervals.

Benefits include periodic in-grade pay increases, 30 days annual leave with pay, sick leave with pay, full medical care, disability retirement pay, retirement pay (three-fourths of annual basic pay at time of retirement), and many other privileges.

Active Duty as a Public Health Service officer fulfills the Selective Service obligation for military duty.

Requirements are U. S. citizenship, and graduation from a recognized school of medicine. For the rank of Assistant Surgeon, at least 7 years of collegiate and professional training and appropriate experience are needed. For Senior Assistant Surgeon, an additional three years, for a total of at least 10 years of collegiate and professional training and appropriate experience, are needed.

Entrance Examinations will include an oral interview, physical examination, and comprehensive objective examinations in the appropriate professional fields.

Application Forms may be obtained by writing to the Surgeon General, United States Public Health Service (P), Washington 25, D.C. Completed application forms must be received *no later than October 9, 1959.*

Bibliography on Arthropod-borne Encephalitis

The National Library of Medicine has just issued a bibliography on Arthropod-borne Encephalitis. Copies may be obtained at no cost upon request to the: Acquisition Division, National Library of Medicine, 7th Street and Independence Ave., S.W., Washington 25, D.C.

American Board of Obstetrics and Gynecology, Inc.

The next scheduled examination (Part 1), written, and review of case histories for all candidates will be held in various cities of the United States, Canada, and military centers outside the Continental United States, on Friday, January 15, 1960. Candidates must submit case reports to the office of the Secretary within thirty days of being notified of their eligibility to Part 1.

Current Bulletins may be obtained by writing to: Robert L. Faulkner, M.D., Executive Secretary and Treasurer, 2105 Adelbert Road, Cleveland 6, Ohio.

National Society for Medical Research

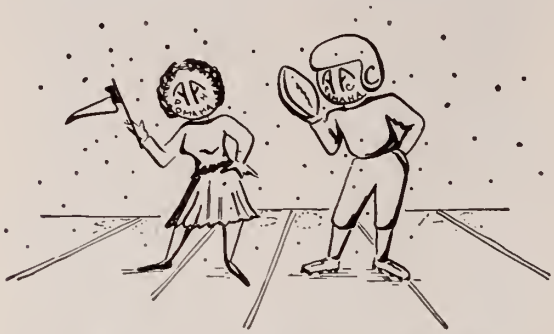
Copies of the Report on the National Conference on the Legal Environment of Medical Science held in Chicago May 27–28, 1959, are available from National Society for Medical Research, 920 South Michigan Avenue, Chicago 5, Illinois.

Directory of Cancer Research Fellows

The National Cancer Institute has just published the first directory of its research fellows since the fellowship program was established in 1937. Section I of the Directory contains the names of 924 persons whose fellowships had been completed previous to April 1, 1958; Section II contains the names of 245 persons whose fellowships extended beyond that date. A brief statement about each fellow tells the highest degree he held at the time of his appointment, the name of the school granting the degree, the type, duration, and place of his fellowship, and the name of his research project. The present position of those whose fellowships had terminated by April 1, 1958 is also given. The introduction to the Directory discusses the history of the program, which was the first of its kind to be supported by the Federal Government.

Most of the former fellows are now engaged in research or teaching or both. About half of the fellows appointed in the early years of the Institute are now permanent members of the Institute's staff in key research positions, and a number of the later fellows have also joined the staff.

Copies of the Directory have been sent to the libraries of appropriate institutions, including four-year colleges, medical schools, and foundations supporting research. A limited number of free copies are available from the National Cancer Institute, Attn.: Information Officer. The 134-page booklet, "Research Fellows of the National Cancer Institute, 1938–1958," is on sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for 45 cents a copy. *(continued)*



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ANNOUNCEMENTS (continued)

The Venereal Disease Branch, Communicable Disease Center, 50 Seventh Street, N. E., Atlanta 23, Georgia, has established and will maintain a mailing key for the distribution of information copies of new VD educational materials as they become available.

Approximately three times a year, collections of world-wide VD literature for professional persons are abstracted and published under the title: "Abstracts of Current Literature on Venereal Disease." This is distributed by a separate mailing key.

Persons desiring to be included on either or both of these mailing keys should write to Dr. William J. Brown at the above address, requesting that they be placed on the Educational Distribution List and/or receive "Abstracts of Current Literature on Venereal Disease" routinely.—U. S. Department of Health, Education and Welfare.

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Prophenpyridamine Maleate	12.5 mg.
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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

The Doctor Business. By Richard Carter, 1st ed., Garden City, N. Y., Doubleday, 1958. 283 pages.

"The main problem . . . in modern health care . . . is an inadequate system of medical practice perpetuated by an unduly powerful confederation of medical societies headed by the AMA." This statement summarizes, in part, the findings of Richard Carter after seven years of research on how medical care is administered to the public. Carter is a medical writer and a reporter who has received the George Polk award for journalism.

Many of the points made are fully appreciated by any thoughtful physician and do not need to be rehashed. An unscrupulous physician can do great harm to the patient and the profession through neglect, kickbacks, fee splitting, ghost surgery and unnecessary surgery. However, comparable indictments could be brought against other professions—and to every trade or industry.

The physician is always the favorite target for attacks because the cost of medical care is often unexpected and therefore bitterly resented. Carter might have spent more time in pointing out the efforts of the medical profession in policing itself for in many areas these have been highly commendable.

The section on medical schools seems to have been developed with an eye toward appeal rather than accuracy. The statements of the AMA and the College Association in the thirties bear little if any relevance to the problems of today.

The AMA does not deliberately hold down the number of physicians in the United States. Unquestionably, federal aid to medical education would permit expansion of some medical schools and the AMA now supports such aid if it is not of a long term nature. Apparently, Carter has never visited communities where medical faculties and medical societies have joined forces to strengthen and expand programs in medical education. His discussion of the AMA and the medical school relationship focuses on points that seem to fit his thesis without presenting the complete picture.

The author is a strong advocate of group practice pre-payment plans. He feels that the patient is the loser under the present individualized practice of medicine and the AMA is the cause of this trouble. Yet he fails to observe that many physicians realize that group practice has advantages and that payment for medical services can be planned efficiently through this mechanisim.

One finds in this book such statements as "the AMA is entitled to enormous credit for making today's physician a far more reliable specimen than yesterday's." Yet he spends considerable yardage in attacking various aspects of the AMA which in the same chapter he calls "the same old hard-bitten trade association." He points out that the average doctor has no room in his life for activity in organized medicine. Thus, physicians with wealth, partnerships or great hunger for power dominate the AMA. He feels that the AMA is undemocratic, cumbersome and inflexible. Yet he fails to point out the excellent job that is performed by the numerous committees and councils of the AMA in bettering medical care.

Today medicine is going through such pains of metamorphosis as have seldom been experienced.

The changing pattern of the population as well as the economic and social structure, at a time when scientific advance has been so rapid, pose problems unparalleled in any profession or trade. Constructive suggestions rather than the black brush of this book are indicated.—JOHN Z. BOWERS, M.D., *Dean*

What We Do Know About Heart Attacks. By John W. Gofman, M.D., Professor of Medical physics, University of California, Berkeley. G. P. Putnam's Sons, New York. 1958. 180 pages. Price: $3.50.

This book, written by one of the pioneers in investigation in the underlying factors of heart disease, is presumably written for the layman. It runs the gamut of causal relationship covering every important factor in the disease such as fatty substances, diet, overweight, male and female differences, familial frequency, tobacco, emotional stress, occupation, physical activity, etc.

The chapter on "The Importance of the Fatty Substances of the Blood (Lipoproteins) for Heart Attacks" is comprehensive albeit technical for the average layman and is the cornerstone of the author's attempt to make it—the Atherogenic Index—the common denominator in the "meshing together of the various clues available that pertain to coronary heart attacks." This the author does quite ably inserting a plea for wider usage of the Atherogenic Index in the preventive concept.

No matter the controversial element in the conclusions, this small volume is worth reading for the physician as well as laymen.—HERMAN SHAPIRO, M.D.

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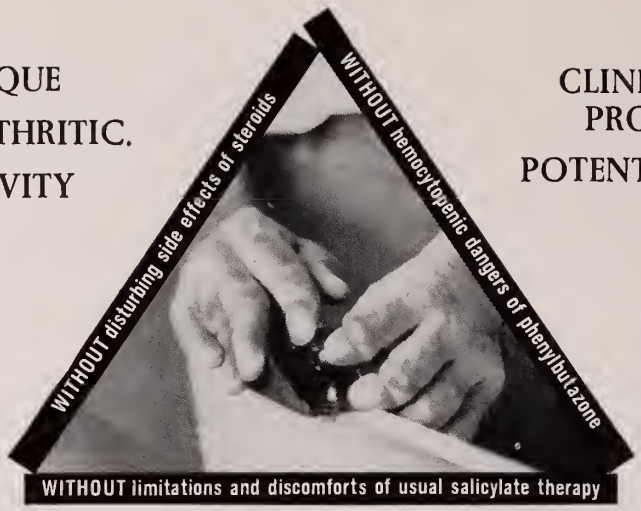

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NOTE: Unless satisfactory relief is obtained, it is advisable gradually to increase dosage by increments of 1 teaspoonful per day until maximum benefit, without side effects, is attained. *In every case the dosage should be adjusted upwards or downwards to assure full therapeutic activity up to the limit of the patient's tolerance (in the absence of gastrointestinal distress or early salicylism).*

Because of the special chemical structure of 'Arthropan', alkalies or other buffering substances are not required to protect the stomach wall and should not be administered with 'Arthropan'.

SUPPLIED: 16 and 8 oz. bottles. Each ml. of 'Arthropan' contains 174 mg. of Choline Salicylate. Each teaspoonful (5 ml.) contains 870 mg.

CITED REFERENCES: 1. Clark, G. M.: Personal Communication, 1958. 2. Feldman, H. A.: Personal Communication, 1958. 3. Scully, F. J.: Treatment of Rheumatic Disorders with Choline Salicylate (to be submitted for publication). 4. Friedland, C. K.: Personal Communication, 1958. 5. Complete data available on request to the Medical Director.

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Recent Wisconsin Licentiates

The following physicians were granted licenses by reciprocity at a meeting of the State Board of Medical Examiners held at Milwaukee, July 15, 1959.

Name	*School of Graduation*	*Year*	*City*
Beltran, J. C.	Taragoza College, Spain	1951	Beloit
Bujard, R. S., Jr.	Baylor University	1958	Madison
Bush, R. D.	University of Minnesota	1956	Manitowoc
Buxbaum, R. C.	University of Pennsylvania	1956	Madison
Carr, R. D.	Ohio State University	1954	Madison
Desch, C. A.	Stritch School of Medicine	1954	Wood
Dougherty, P. J.	University of Illinois	1956	Milwaukee
Drom, R. E.	University of Illinois	1955	Glen Ellyn Woods, Illinois
Durkin, J. W., Jr.	University of Vermont	1951	Milwaukee
Edwards, C. D.	University of Wisconsin	1950	Spooner
Fruchtman, R. B.	University of Minnesota	1956	Milwaukee
Funcke, W. E.	University of Iowa	1956	Beaver Dam
Goldstein, E. S.	Albany Medical College	1953	Madison
Graves, R. H.	Indiana University	1958	Indianapolis, Indiana
Gulick, M. L.	Washington University	1958	Wisconsin Dells
Hagenbucher, J. T.	George Washington University	1957	Madison
Hilgedick, W. R.	University of Minnesota	1955	Ladysmith
Hoffman, J. R.	Ohio State University	1955	Milwaukee
Jacoby, J. J.	University of Minnesota	1942	Milwaukee
Jerofke, Alfred	University of Heidelberg	1953	Mercer
Kastrul, J. J.	Northwestern University	1958	Milwaukee
Kim, K. S.	Seoul Medical School	1951	Monroe
Kirschenbaum, M. B.	University of Chicago	1957	Chicago, Illinois
Krehl, W. A.	Yale University	1957	Milwaukee
Lamb, Harry	Georgetown University	1948	Sturgis, Michigan
Lloyd, J. D.	Indiana University	1958	Milwaukee
Lucas, A. M.	Marquette University	1958	Duluth, Minnesota
Mackey, J. P.	St. Louis University	1958	Madison
Mark, G. A.	Northwestern University	1956	Milwaukee
McKenna, J. E.	University of Wisconsin	1957	Oakland, California
Neumann, A. K.	New York University	1958	Marathon
Park, R. K.	University of Michigan	1953	Appleton
Pederson, D. P.	University of Rochester	1951	Marshfield
Phelps, R. D.	University of Nebraska	1958	Burlington
Raney, E. H.	University of Illinois	1955	Chicago, Illinois
Reinbold, W. B.	Ohio State University	1958	Milwaukee
Samios, C. J.	Northwestern University	1955	Joliet, Illinois
Schibly, W. J.	University of Nebraska	1958	Green Bay
Schmidt, J. C.	University of Illinois	1955	Platteville
Scholten, W. A., Jr.	Northwestern University	1954	Beloit
Seilin, Josef	University of Illinois	1915	Antigo
Selmants, Steven	Ohio State University	1952	Toledo, Ohio
Skaggs, T. R.	St. Louis University	1958	Milwaukee
Stormont, J. R.	George Washington University	1954	Monroe
Wheatley, R. E.	McGill University	1954	Madison
Wright, T. E.	Ohio State University	1958	Milwaukee

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News of Wisconsin Physicians

Doctor Aktekin Practices in Wisconsin

A Turkish radiologist, Dr. Hikmet Aktekin, who located in Superior earlier this year, has begun spending one day a week at the Hayward Memorial Hospital. He is associated with a radiologist group from Duluth, Minnesota, but confines his practice to northern Wisconsin.

Dr. Aktekin received a medical degree from Istanru University, Turkey, and has completed five years of specialty training at various hospitals in the United States, spending a year in pathology and four years in radiology. Before locating in Wisconsin he had been at the Wayne County General Hospital in Eloise, Michigan, as an associate radiologist.

Doctor Phelps Locates in Burlington

It was announced in August that Dr. R. D. Phelps has joined the Mastalir-Baker Clinic in Burlington. A native of Nebraska, Doctor Phelps graduated from the University of Nebraska Medical School in 1958 and interned at Salt Lake City, Utah.

Doctor Resumes Superior Practice

Dr. Robert Mataczyski, recently discharged from service, has returned to practice in Superior with *Dr. Conrad Giesen* and *Dr. Richard Fruehauf*. He had practiced for a year at Superior before entering the U.S. Army in 1957. Doctor Mataczyski was released with the rank of captain and had been stationed as assistant chief of obstetrics and gynecology in the Army Hospital at Wurzberg, Germany.

A 1955 graduate of the University of Wisconsin Medical School, Doctor Mataczyski interned at St. Luke's Hospital, Duluth, Minnesota.

Rosendale Doctor Marks 50th Anniversary

Dr. Milo Scheid's fiftieth year as a practicing physician in Rosendale and the surrounding territory was celebrated at an open house held August 30. A luncheon was served following a program in recognition of the doctor. The occasion also was in honor of the Scheid's golden wedding anniversary.

St. Croix Falls Clinic Increases Staff

With the addition of a specialist in surgery, Dr. L. L. Olson, the St. Croix Falls Clinic now is comprised of six physicians. Doctor Olson came to St. Croix Falls on July 26 following four years of a surgical residency at the Veterans Administration Hospital in Minneapolis, Minnesota. He had previously graduated in 1954 from the University of Washington and interned at St. Joseph's Hospital in St. Paul.

Physicians whose names appear in italic are members of the Society.

Doctor Graves Locates in Campbellsport

Having recently completed interning at Indianapolis General Hospital, Dr. R. H. Graves located at Campbellsport in mid-August. He was a 1958 graduate of the University of Indiana Medical School. His coming brought to an end a search that the community and local doctors have conducted during the past few years for a practitioner to help meet the needs of Campbellsport citizens.

County Hospitals Medical Director Hired

Dr. S. A. Shaffer assumed the duties of medical director of the Middle River Sanatarium and Douglas County General Hospital in September. Doctor Shaffer received his medical degree from the University of Pennsylvania, interned and served a one-year residency at Los Angeles County General Hospital, and had a private practice in internal medicine in Los Angeles. He has served as instructor in his field at the University of Southern California School of Medicine and was senior physician at the W. T. Edwards Hospital for chest diseases, Tallahassee, Florida, at the time he accepted the Wisconsin positions.

Doctor Shaffer holds memberships in the American Medical Association, the American Trudeau Society, the California Society of Internal Medicine, the American College of Cardiology, and the American College of Chest Diseases.

New Officers of Golf Group

New officers of the Wisconsin State Medical Golf Association are: *Drs. N. M. Clausen*, Madison, president; *P. J. Purtell*, Milwaukee, vice-president; *S. W. Hollenbeck*, Milwaukee, secretary-treasurer; and *Drs. M. T. O'Meara*, La Crosse, and *E. L. Watson*, Ripon, directors. They were elected at the annual meeting August 12 at the Maple Bluff Country Club, Madison.

State Heart Delegates

Seven delegates have been named to represent Wisconsin at the annual meeting and scientific sessions of the American Heart Association in Philadelphia, Oct. 23–27, according to William C. Proctor, Eau Claire, Wisconsin Heart Association president.

The delegates who may attend are: Proctor; *Dr. Robin Allin* and *Dr. Charles W. Crumpton*, both from Madison; C. Ellis Goldstein, Racine; *Dr. D. Joseph Freeman*, Wausau; and *Dr. Robert A. Frisch* and Charles S. Quarles, both from Milwaukee.

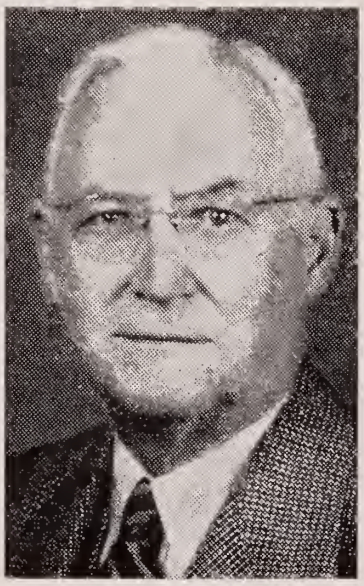
(continued)

On World Medical Council

Dr. Gunnar Gundersen, La Crosse, was elected vice chairman of the Council of The World Medical Association at its 13th General Assembly held in Montreal, Canada, September 6–12.

Dr. F. G. Connell Honored

Dr. F. G. Connell, Oshkosh, first president of the Wisconsin Surgical Society, was honored at a banquet September 19 during the semi-annual meeting of the Society at Mercy Hospital in Oshkosh. The honor was in recognition of his contributions to the Society and to the medical profession in general. He was presented with a silver plate bearing the engraved names of WSS founders.



Doctor Connell
—Photo courtesy OSHKOSH DAILY NORTHWESTERN

Dr. Wilson Cunningham Honored

Dr. Wilson Cunningham, known as the "father of medicine" in southwest Wisconsin, was honored September 19 at the Dairy Day festivities in Platteville. The honor was in recognition of his 59 years of service in the medical profession to his community. It also marked his 87th birthday.

Doctor Cunningham received his medical education from Northwestern University and Mercy Hospital in Chicago, Illinois. He came to Platteville in 1900, and in January 1901 the Cunningham Hospital, at that time the first one on that side of Madison, was opened. Doctor Cunningham was the first chief of staff for the new Platteville Municipal Hospital and served in that capacity from December, 1949, to December, 1954, and was then made chief emeritus. He was honored in 1954 by the Executive Committee of the Wisconsin Anti-Tuberculosis Association for his long-time service to the voluntary tuberculosis control movement in Wisconsin.

New Fellows of ACS

Fourteen Wisconsin physicians were among 1,015 surgeons who were inducted as new Fellows of the American College of Surgeons in ceremonies closing the annual five-day Clinical Congress of the organization on October 2. The ACS, founded in 1913 to establish standards of competency and character for specialists in surgery, has grown in 46 years' time from a founding group of 450 to a total membership of more than 23,250.

Physicians who received the Fellowship are: *William W. Chandler*, Appleton; *Mason S. LeTellier* and *James K. Theisen*, Green Bay; *William B. Gallagher*, *Adolph L. Gundersen*, and *Sigurd B. Gundersen, Jr.*, La Crosse; *James F. McIntosh* and *John T. Phelan*, Madison; *James A. Boren*, Marinette; *John T. Hotter*, *William M. Pfeifer*, *John D. Silbar*, and *William P. Wendt*, Milwaukee; and *William C. Harris*, Racine.

Honor Doctor Zenner at Cadott

Friends throughout the Cadott community honored their local physician, *Dr. Clarence E. Zenner*, at a testimonial dinner held September 9. The occasion was in recognition of a quarter of a century of service to the community. Members of the Chippewa County Medical Society, of which Doctor Zenner has been president, were also invited to the affair.

Doctor Zenner completed his medical education at Marquette University in 1933. After a year's internship at Milwaukee County General Hospital and a year of residency training at Milwaukee General and Milwaukee County Emergency Hospital, he decided to establish himself in private practice. Cadott was his choice.

THIRD AND TWELFTH DISTRICTS

Doctor Evans Talks in Kansas

Dr. Alfred S. Evans, head of the University of Wisconsin department of preventive medicine, was a guest lecturer at the Third Annual Symposium on Infectious Diseases on September 25 at the University of Kansas Medical Center.

Doctor Evans talked on, "Wheezes, Sneezes and Other Diseases." He outlined efforts to conquer the common cold and allied infections. He also pointed out that "from the misty spray of a sneeze" it is now possible to dimly discern a number of viruses that may cause colds. Two of these viruses, called JH and 2060, are definitely responsible for some coldlike illnesses. However, Doctor Evans, reminded his colleagues that more than 80 per cent of all respiratory illness results from unknown causes and there is as yet no effective cold vaccine.

WISCONSIN PRESS reports:

DOCTORS DO NOT WANT "COOKBOOK" INSTRUCTION

Dr. David N. Goldstein: Speaking to a group of general practitioners attending a two-day scientific training session in Milwaukee in September, Doctor Goldstein expressed his belief that family doctors do not want "cookbook" medical instruction. He expressed concern over postgraduate instruction for family doctors. He said such education never has been "optimally developed" or "well defined." The Kenosha physician said there has been an increasing emphasis for several years on the "practical aspects" of medical education. Many people appear to believe that general practitioners "seek a cookbook sort of exposition on any particular topic" with precise directions, Doctor Goldstein said. "This I believe to be wholly false," he declared. Continuing, he told the group: "We emphatically do not want superficial, dogmatic and nonintellectual instruction. This attitude seems to be appearing more and more frequently among our colleagues in the specialties and among educators. The time is near when we must actively express our dissatisfaction with instruction that fails to meet our standards if we hope to accomplish our primary goal of improvement in patient care."

DIABETES CAN BE CONTROLLED WITH NEW ORAL DRUG

Dr. Robert S. Baldwin: At the Scientific Assembly of the Wisconsin Academy of General Practice in Milwaukee in September, Doctor Baldwin reported that use of a new oral drug for treatment of diabetes is effective in two out of three cases tested. Doctor Baldwin described his finds to physicians attending the meeting. He discussed treatment with a number of oral drugs, used recently as partial replacements for insulin injections, and said that one—called DBI—has been effective not only in mild adult-stable diabetics, but also in more difficult "brittle" cases and among youngsters. Among 51 patients, Doctor Baldwin said he found excellent results with 22 and good results with 11. Six of 11 children under 15 years of age were among these, he said.

PATIENT MAY NOT REVEAL TRUE FACTS IN LAWSUIT CASES

Dr. Chester C. Schneider: You can't believe the patient when his injuries are the subject of a lawsuit. The industrially injured or sick patient is entitled to the best medical care, and should have his equities guarded at every turn. . . . Every case coming to a physician deserves thorough study . . . (but) the physician has responsibility not only to the patient but to the public as well. The trouble is that under such circumstances the patient's statements may be either downright untrue or exaggerations. A fall of five feet may become 20; a lift of 25 pounds may become 100; mild discomfort becomes terrible pain. One of the major risks is attributing the effects of old injuries or even birth defects to the accident in question. A careful history taking sometimes will explain all the symptoms. He cautioned doctors who were to testify in disability cases to take their notes with them. Too often they think they can testify from memory because they do not anticipate the detailed questioning they get from attorneys, and they "come away from the ordeal hostile and humiliated." Sometimes there is too much willingness on the doctor's part to aid the cause of one side or another, and this accounts for shocking differences in medical testimony. However, there is plenty of room for legitimate disagreement on the long term effects of injury, and mere disagreement does not of itself indicate either dishonesty or incompetence.

ELECTRONIC FILTERING CAN AID STUDY OF HEART NOISES

Dr. George A. Hellmuth: The trouble with heart noises is that most of them are very low pitched, an octave or two below middle C on the piano, and many are faint. On the other hand, some noises from leaky valves in people with high blood pressure range around E above middle C. They are hard to sort out from the general background noise. But, with suitable electronic filtering, the key sounds can be isolated, studied and compared with recordings of electrical impulse in the heart nerves and with pressure readings in the heart chambers.

(continued)

DOCTOR'S RESPONSIBILITY IN TREATING ALCOHOLICS

Dr. Earl B. Clark: A Milwaukee pathologist, speaking at a seminar at the central YMCA in Milwaukee in September, said doctors are lagging in assuming responsibility for treating alcoholics. "Doctors haven't thought about alcoholism as a medical problem. The general practitioner thinks it's a problem for the psychiatrist." Only one Milwaukee general hospital will admit alcoholics for treatment and only that hospital has an out-patient alcoholic clinic, Doctor Clarke said.

STRIKES AT HOSPITALS FOR REFUSAL TO TREAT ALCOHOLICS

Dr. N. J. Bradley: In discussing treatment of the alcoholic at a seminar in Milwaukee's YMCA in September, Doctor Bradley, superintendent of the Willmar (Minn.) state hospital, said that it showed ignorance on the part of hospitals to refuse to treat alcoholics. The usual reason given, he said, is that alcoholics are noisy. But with modern treatment methods the alcoholic can be an "exemplary patient," he said. "They behave twice as well as a lady having a baby," he said. Doctor Bradley said that he made many referrals of alcoholics to clergymen but none to doctors, because the latter are not interested in such cases. He said that if preachers had a chief fault in their dealings with drunkards it was that they were too sympathetic.

URGES ALERTNESS IN CHECKING "OFF-CENTER" EYES IN INFANTS

Dr. Malcolm McCannel: Parents who wait for their baby to "grow out of" a crossed eye are dooming the child to poor vision or no vision in the affected eye, according to Dr. Malcolm McCannel, eye specialist on the faculty of the University of Minnesota medical school. In speaking to a group of some 300 physicians during the annual meeting of the Wisconsin Academy of General Practice held in Milwaukee in September, Doctor McCannel urged the family doctors to be on the alert for even a slightly off-center eye in an infant patient, so that parents can be referred to a specialist and treatment to preserve the sight started immediately. He said it is impossible to restore or improve vision in 99 per cent of the children brought to the specialist when they are 6 or 7 years old. A baby's eyes may "wander a little" for the first 10 or 12 months of life without anything being wrong, Doctor McCannel said, but failure to focus properly after that calls for medical attention.

SMOKING CONTRIBUTES TO PROGRESS OF DEAFNESS

Dr. Graham Smith: In a discussion of deafness involving the nerves of the ear, Dr. Graham Smith, Minneapolis ear specialist, told the physicians attending the annual meeting of the Wisconsin Academy of General Practice in Milwaukee in September that the bad effect of smoking on this condition was demonstrated by the fact that ear specialists are giving up smoking, "just as chest men are giving it up because they're afraid of lung cancer." He said smoking contributed to the progress of the deafness by its action in constricting blood vessels near the surface of the body, thus lowering the blood supply to the affected nerves.

What's New at the Medical Schools

Doctor Kempinsky Appointed

Warren H. Kempinsky, M.D., an Assistant Professor of Neurology at Washington University Medical School, St. Louis, on September 1 joined the Marquette University School of Medicine faculty and the medical staff of the Milwaukee County Hospital.

Doctor Kempinsky will be a full-time neurologist at the Milwaukee County Hospital and the medical school. He will be in charge of the medical neurology services at the hospital, including the electroencephalography laboratory, and will collaborate in further development of neuroradiology.

Doctor Kempinsky received his B.S. degree from the University of Washington, Seattle, in 1941 and his M.D. from Washington University in St. Louis in 1944.

Doctor Kempinsky's present research is upon cerebral blood flow in patients with cerebrovascular disease. In the past he described the cerebral injury potential produced by experimental lesions in animals using a technique for direct current recording, demonstrating the physiological basis for cerebral diaschisis, and the cortical representation of the vestibular nerve. He wrote original descriptions of paraplegia due to vertebral osteoporosis and of paraplegia due to fusiform aneurysm of the abdominal aorta.

Dr. Kempinsky is a member of the American Academy of Neurology, the New York Academy of Science, the Association for Research in Nervous and Mental Disease, St. Louis Society for Neurology and Psychiatry, American Medical Association, Missouri State Medical Society, and the St. Louis County Medical Society.

South American Expedition

Two University of Wisconsin Medical Center scientists are taking part in an expedition to South America during the 1959–60 school year. Under the terms of a grant from the National Science Foundation, the expedition is headed by Dr. Peter Morrison, Associate Professor of Physiology, assisted by Dr. Enrique Valdivia, Assistant Professor of Pathology and left July 1. The purpose of the trip is to carry on physiological studies of the natural adaptation of human subjects and mammals to temperature regulations and respiration in the cold and high altitudes. These studies are being carried out in association with the University of Bahia, Salvador, Brazil, the University of Chile in Santiago and the University of San Marcos, Lima, Peru. While in South America, Doctor Valdivia presented a paper at the Symposium of Mechanisms of Adaptation to Hypoxia of the XXI International Congress of Physiology, in Buenos Aires, Argentina, August 4–18.

"Dean's Hour" Placed in Curriculum

Beginning September 15 freshmen, sophomore, and junior medical students at Marquette University School of Medicine started participating in a "Dean's Hour" every Tuesday from 4:00 to 5:00 p.m. This hour, according to John S. Hirschboeck, M.D., Dean of the medical school, is set aside for special lectures and panel programs conducted by the students and faculty.

Photographers Receive Awards

Two photographers from Marquette University School of Medicine received awards at the 29th annual meeting of the Biological Photographic Association, Inc. in Montreal August 31–September 3. They are Anthony M. Kuzma and Robert Teevan. Kuzma, a medical photographer in the Department of Pathology, won a second prize for a color print of "The unhappy cancer cell." Teevan, a medical photographer in the Department of Art and Photography, received an honorable mention for a colored print of "Malignancy—skin."

Four Participate In ACP Meeting

Four faculty members from Marquette University School of Medicine participated in the regional meeting of the American College of Physicians in Indianapolis September 26. They are Burton A. Waisbren, M.D., Assistant Clinical Professor of Medicine, who discussed "Pyogenic osteomyelitis of the spine treated with combinations of antibiotics and gamma globulin;" and Robert W. Ewer, M.D., Instructor in Medicine, John Arkins, M.D., Clinical Instructor in Medicine, Bert Heffernan, M.D., and Edward J. Lennon, M.D., Instructor in Medicine, who presented "Increased urinary excretion of catechol amines in the absence of known chromaffin tumors."

Additional Grants Received From USPHS

Marquette University School of Medicine has received an additional $68,277 in renewal research grants from the United States Public Health Service supplementing the $70,918 reported in the September issue of the *Wisconsin Medical Journal.*

Doctor Krehl Receives Grant

Willard A. Krehl, M.D., Ph.D., Associate Professor of Medicine at Marquette University School of Medicine, has received a $5,000 grant from the Nancy Sayles Day Foundation for research in the field of nutrition in relation to renal disease.

New Wisconsin Licentiates

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 14–16, 1959.

Name	*School of Graduation*	*Year*	*City*
Adlam, R. T.	Marquette University	1958	Milwaukee
Alvarez, Ubaldo	University of Cartagena	1953	Medford, Minnesota
Amundsen, M. A.	Northwestern University	1958	Rochester, Minnesota
Anderson, J. A.	Marquette University	1958	Denver, Colorado
Andres, F. I.	Marquette University	1958	Milwaukee
Baldwin, R. C.	University of Illinois	1958	Watertown
Barber, D. D.	University of Wisconsin	1958	Waukesha
Barbo, Dorothy M.	University of Wisconsin	1958	Milwaukee
Bauer, C. R.	Marquette University	1958	Clear Lake
Bloxdorf, J. W.	University of Wisconsin	1958	Milwaukee
Bowe, C. T.	Marquette University	1958	Cadott
Brekken, A. L.	University of Wisconsin	1958	Stoughton
Bruhn, I. J.	University of Wisconsin	1958	Walworth
Bryan, G. T.	University of Wisconsin	1957	Madison
Buckley, Theresa L.	Marquette University	1958	Milwaukee
Carlovsky, R. E.	University of Wisconsin	1958	Fond du Lac
Chalkley, T. H. F.	University of Wisconsin	1958	Lake Geneva
Conrad, A. B.	Marquette University	1958	South Bend, Indiana
Ender, K. E.	University of Wisconsin	1958	Chippewa Falls
Fick, K. R.	University of Basle	1957	Milwaukee
Gant, G. C.	University of Wisconsin	1958	Madison
Gates, R. F.	Northwestern University	1958	Iowa City, Iowa
Grossman, T. W.	Marquette University	1958	Milwaukee
Hamm, H. J.	Marquette University	1958	Shorewood
Harris, R. C.	University of Wisconsin	1958	Madison
Haselow, J. R.	Marquette University	1958	Fremont
Heiden, J. D.	University of Wisconsin	1958	Madison
Heinzelmann, C. M.	Marquette University	1958	Milwaukee
Hogan, W. J., Jr.	Marquette University	1958	Milwaukee
House, J. W., Jr.	Marquette University	1958	Milwaukee
Howards, L. A.	University of Wisconsin	1958	Milwaukee
Huang, A. T.	Peiping Union Medical School	1943	Lawton, Oklahoma
Jasculca, J. H.	Marquette University	1958	Milwaukee
Johnson, W. D.	University of Illinois	1955	Milwaukee
Jones, W. P. G.	University of Sheffield	1953	Milwaukee
Jumes, M. G.	University of Wisconsin	1958	Madison
Kaufmann, J. H.	University of Wisconsin	1957	APO 677, New York, New York
Keller, R. A.	University of Wisconsin	1958	Milwaukee
Khajezadeh, Hooshang	Marquette University	1958	Milwaukee
Kisley, A. J.	University of Wisconsin	1958	Cudahy
Kneubuhler, H. A., Jr.	University of Wisconsin	1958	Madison
Koenen, C. T.	Marquette University	1958	Milwaukee
Kralicek, E. F.	Marquette University	1958	Dickinson, North Dakota
Kretchmar, L. H.	Northwestern University	1958	Milwaukee
Kuhn, M. J., Jr.	Marquette University	1958	Milwaukee
Larson, J. A.	Marquette University	1958	Oakland, California
Leahy, J. J.	Northwestern University	1945	Omaha, Nebraska
Legler, G. D.	University of Wisconsin	1958	Baltimore, Maryland
Leicht, T. R.	University of Wisconsin	1958	Madison
Lerdahl, Kenneth	University of Wisconsin	1958	Milwaukee
Maier, K. J.	Marquette University	1957	Evanston, Illinois
Marcich, Z. P.	University of Rome	1950	Milwaukee
McKenty, J. D.	University of Manitoba	1953	Marshfield
Meekin, F. A.	Marquette University	1958	Laramie, Wyoming
Mielke, J. E.	University of Wisconsin	1958	Rochester, Minnesota

(continued)

NEW WISCONSIN LICENTIATES (continued)

Name	*School of Graduation*	*Year*	*City*
Palabrica, A. R.	Manila Central University	1954	Milwaukee
Parr, J. L.	University of Wisconsin	1958	Cleveland, Ohio
Pritzl, D. J.	University of Wisconsin	1958	Marshfield
Puletti, Flavio	University of Florence	1947	Madison
Rahr, H. C.	University of Wisconsin	1958	Luxemburg
Riesch, J. D.	University of Wisconsin	1958	Milwaukee
Rucci, E. P.	Marquette University	1954	Great Lakes, Illinois
Schmidt, C. S.	University of Wisconsin	1958	Madison
Schmidt, J. R.	Marquette University	1958	Milwaukee
Schmidt, R. D.	University of Wisconsin	1958	Milwaukee
Scrimenti, R. J.	Marquette University	1958	Milwaukee
Sherwood, D. L.	University of Wisconsin	1958	Chicago, Illinois
Shovers, Philip	University of Wisconsin	1958	Cleveland, Ohio
Slightam, P. E.	University of Wisconsin	1958	Madison
Smith, V. W.	University of Chicago	1954	Verona
Stein, J. D.	University of Wisconsin	1958	Clintonville
Stein, P. L.	University of Wisconsin	1958	Milwaukee
Temple, R. L.	University of Wisconsin	1958	Wood
Treacy, W. L.	Marquette University	1957	Rochester, Minnesota
Treppert, D. A.	University of Wisconsin	1958	Madison
Truszkowski, A. J.	Marquette University	1958	Milwaukee
Tupper, J. R.	Marquette University	1958	Wauwatosa
Turgai, Valerio	University of Madrid	1951	South Milwaukee
Urlakis, K. J.	Marquette University	1958	South Milwaukee
VanGiesen, D. I.	University of Wisconsin	1958	LaCrosse
Wax, J. I.	University of Wisconsin	1958	Omaha, Nebraska
Weiss, J. W.	University of Wisconsin	1958	Milwaukee
Wiedenbauer, Margaret	University of Wisconsin	1955	Strum
Wiesen, R. L.	Marquette University	1958	Wood
Wimberg, Elizabeth L.	Marquette University	1958	Port Hueneme, California
Winter, B. V.	Northwestern University	1958	Union Grove
Winters, W. D.	Marquette University	1958	Milwaukee
Wolski, L. R.	Marquette University	1953	Milwaukee
Wong, H. C.	University of Wisconsin	1958	Madison
Wright, I. V.	Marquette University	1958	San Diego, California
Wyman, J. B.	University of Wisconsin	1958	River Falls
Zabors, T. E.	Marquette University	1958	Milwaukee
Zboralske, F. F.	Marquette University	1958	West Allis
Ziolkowski, J. S.	Marquette University	1958	Milwaukee

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Society Records

New Members

T. C. Smith, 1300 University Avenue, Madison.
A. B. Crummy, Jr., 1300 University Avenue, Madison.
J. H. Morledge, 30 South Henry Street, Madison.
Janusz Belza, 406 Main Street, Menomonie.
W. L. Deardorff, 2212 West State Street, Milwaukee.
C. E. Rogers, *U. S. Naval Hospital, St. Albans, New York.
F. D. Murphy, Jr., 610 Honey Creek Parkway, Milwaukee.
H. T. Grinvalsky, St. Michael's Hospital, Stevens Point.
E. A. Renquest, Box 51, Grantsburg.
L. M. Baertsch, Hayward Clinic, Hayward.
L. W. Lakritz, 419 Pleasant Street, Beloit.
B. R. Erickson, Plum City.
Ismail Nik Nevin, St. Mary's Hospital, Rhinelander.
J. D. Edson, 1417 Longview Street, Madison.
E. O. Sheldon, Jr., 6 Sherman Terrace, Madison.
R. A. Gruesen, 401 Presidential Lane, Madison.
H. A. Devine, Jr., 1912 Atwood Avenue, Madison.

Changes of Address

Jordan Frank, *Chicago Heights, Illinois, to P.O. Box 55, U.S. Air Force Hospital, Wright–Patterson Air Force Base, Ohio.
D. E. Howland, *Wichita Falls, Texas, to 7505th U.S. Air Force Hospital, APO 232, New York, New York.
C. H. Kratchovil, *Randolph Air Force Base, Texas, to European Office ARDC, APO 633, New York, New York.
G. M. Kroncke, Madison, to 1335 South Sherwood, Charleston, South Carolina.
P. D. Nelson, *Philadelphia, Pennsylvania, to Community Hospital, Norton, Virginia.
D. M. Connors, Rhinelander, to 720 South Brooks Street, Madison.
E. M. Baldigo, Milwaukee, to 2319 Creekside Road, Santa Rosa, California.
R. E. Cullen, Fond du Lac, to 3145 "O" Street, Lincoln, Nebraska.
W. W. Fieber, Lancaster, to 104 South Main Street, Fond du Lac.
H. J. Heeb, Milwaukee, to Howey in the Hills, Florida.
W. F. Kennedy, *Fond du Lac, to 3729 North 75th Street, Milwaukee.
D. L. Schaefer, Milwaukee, to University of Michigan Hospital, Ann Arbor, Michigan.
J. A. Spector, Wood, to 1212 West Wisconsin Avenue, Milwaukee.
F. G. Stergiades, APO 949, Seattle, Washington, to Columbia Hospital, Milwaukee.
Edyth C. Swarthout, La Crosse, to Box 398, West Salem.
J. I. Sanders, Brighton, Massachusetts, to 124 Russett Street, Worcester, Massachusetts.
D. J. Cohen, *Milwaukee, to U. S. Naval Hospital, Pensacola, Florida.
G. P. Gredler, South Milwaukee, to 305 Court Street, Janesville.
J. S. Sachs, Milwaukee, to Colby College, Waterville, Maine.
R. W. Cranston, Madison, to 2820 Branch Street, Duluth, Minnesota.
E. F. Hill, Spring Valley, to 2742 East, 4510 South, Salt Lake City 17, Utah.
C. D. Sargeant, Manitowoc, to Baileys Harbor.
E. H. Schlomovitz, Milwaukee, to 1724 Northwest 8th Court, Miami 36, Florida.
A. J. Venables, Wausau, to St. Ann's Hospital, Watertown, South Dakota.
W. R. Schatz,* Racine, to 20th Station Hospital, APO 180, New York, New York.
F. C. Schoene, Waukesha, to Veterans Administration Hospital, Phoenix, Arizona.
C. A. Taylor, Jr.,* Madison, to 3320th U.S. Air Force Hospital, Amarillo Air Force Base, Texas.
D. F. Hammond, Barron, to 2332 East Dartmouth, Englewood, Colorado.
J. J. Leahy, Park Falls, to 3108 Lincoln Boulevard, Omaha 31, Nebraska.
E. P. Peterson, Madison, to Eastern State Hospital, Medical Lake, Washington.
R. A. McCormick, Milwaukee, to St. Vincent Hospital, Green Bay.
S. N. Kenwood, San Angelo, Texas, to 5700 North Shoreland Avenue, Milwaukee.
D. A. Roth, Milwaukee, to 1620 Revere Drive, Brookfield.
M. J. McCarthy, Hillsboro, to 1697 ALA MOANA, Honolulu 15, Hawaii.
D. U. Cookson,* Madison, to Box 96, U.S. Air Force Hospital Eglin, Eglin Air Force Base, Florida.

Marriages

Dr. L. W. Peterson, Sun Prairie, to Mary Johnson on June 30.

*Military Service.

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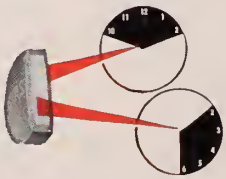

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One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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Obituaries

Dr. H. J. Caldwell, a Columbus physician and surgeon, died August 23 at the age of 59.

Born in Arlington in 1900, he was a 1924 graduate of Rush Medical College. Following an internship at Milwaukee Hospital, Doctor Caldwell located in Columbus where he had remained for the past 35 years.

Doctor Caldwell was a member of the State Medical Society of Wisconsin, the Columbia-Marquette-Adams County Medical Society, and the American Medical Association.

Immediately surviving are two sons, Hugh, Jr., Columbus, and Curtis, Madison.

Dr. W. C. Stewart, 74, passed away August 23. He had been a practicing physician and gynecologist in Kenosha since 1916.

Doctor Stewart was born at Thompsonville, Illinois, in 1884. Prior to completion of h's medical training at the St. Louis University School of Medicine in 1912, he had taught school. He established his Kenosha office after practicing a few years in St. Louis, Missouri.

Memberships held by Doctor Stewart included those with the State Medical Society of Wisconsin, the Kenosha County Medical Society, the American Medical Association, the Association of American Physicians and Surgeons, Inc., and was a member of the board of directors of the National Foundation. He headed the State Society's House of Delegates in 1949, had served a 1935–1936 term as president of the county society and had also been a delegate of the county.

His widow and two sons survive.

Dr. E. H. Darling, retired Milwaukee general practitioner, died at his home August 25. He was 75 years of age.

Doctor Darling was born in 1883. Immediately upon graduation from Marquette University School of Medicine in 1907 he began practice in Milwaukee. Ill health forced him into retirement several years ago.

He had previously been a member of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, and the American Medical Association.

Two dentist sons survive.

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Medical Meetings - Postgraduate Courses

Minnesota Medical Continuation Courses

The following medical continuation courses will be presented at the Center for Continuation Study, University of Minnesota:

Nov. 2–6, 1959: Gastrointestinal Radiology for Radiologists

Nov. 16–18, 1959: Fractures for General Physicians

Nov. 19–21, 1959: Physical Medicine for Specialists

Jan. 11–13, 1960: Ophthalmology for Specialists

Jan. 21–23, 1960: Surgery for Surgeons

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14.

North Shore Hospital Lecture

The second lecture in the Tenth Annual North Shore Hospital lecture series on "Office Management of Emotional Disorders" will be held at the hospital, 225 Sheridan Road, Winnetka, Illinois, on Wednesday, November 4, starting at 8:00 P.M. Dr. C. Knight Aldrich, professor and chairman of the Department of Psychiatry, University of Chicago, will discuss "Evaluation and Understanding of Emotional Disorders." Postgraduate credit is allowed by the Commission on Education of the AAGP.

Eyes in Industry

The Institute of Industrial Health of the University of Cincinnati announces a course of instruction in *Industrial Eye Problems* will be given during the week of January 18–22, 1960. It will be presented by the Institute of Industrial Health in cooperation with the Department of Ophthalmology.

The objective of the course is to enable the industrial physician to recognize significant eye pathology, understand the limitations and abilities of persons with defective vision and perform basic eye examination procedures. Emphasis throughout will be on the needs of the industrial physician.

Current concepts regarding vision requirements for specific job categories will be discussed. Eye examination procedures and vision screening devices will be demonstrated. Opportunity for informal discussion of practical problems will be provided.

Physicians interested in attending the course should write for an application blank to: A/60, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

The registration fee will be $100.

(continued)

WISCONSIN CALENDAR COMING EVENTS

1959

Oct. 28–30: Wisconsin Nurses Association, annual convention, Hotel Pfister, Milwaukee.

Oct. 29: Occupational Health Nurses' Section, annual meeting, Hotel Pfister, Milwaukee.

Nov. 12–13: Postgraduate course, "Fractures in General Practice," UW Medical Center, Madison.

Nov. 18: Dr. Malcolm F. Rogers Lecture, Marquette University School of Medicine, Milwaukee.

Nov. 19: Dr. Malcolm F. Rogers Lecture, University of Wisconsin Medical School, Bardeen Auditorium, Madison.

Nov. 21–22: North Central Medical Conference, Hotel Leamington, Minneapolis, Minnesota.

Nov. 24: Meeting, Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

1960

Jan. 19: Circuit teaching program, Vernon County Memorial Hospital, Viroqua.

Jan. 20: Circuit teaching program, Waupun Memorial Hospital, Waupun.

Jan. 21: Circuit teaching program, Elks Club, Appleton.

Feb. 11–12: Postgraduate course, "Laboratory Diagnosis for General Practitioners, UW Medical Center, Madison.

Feb. 18: Postgraduate course in therapeutics, UW Medical Center, Madison.

Mar. 10–12: Postgraduate course in neurological problems, UW Medical Center, Madison.

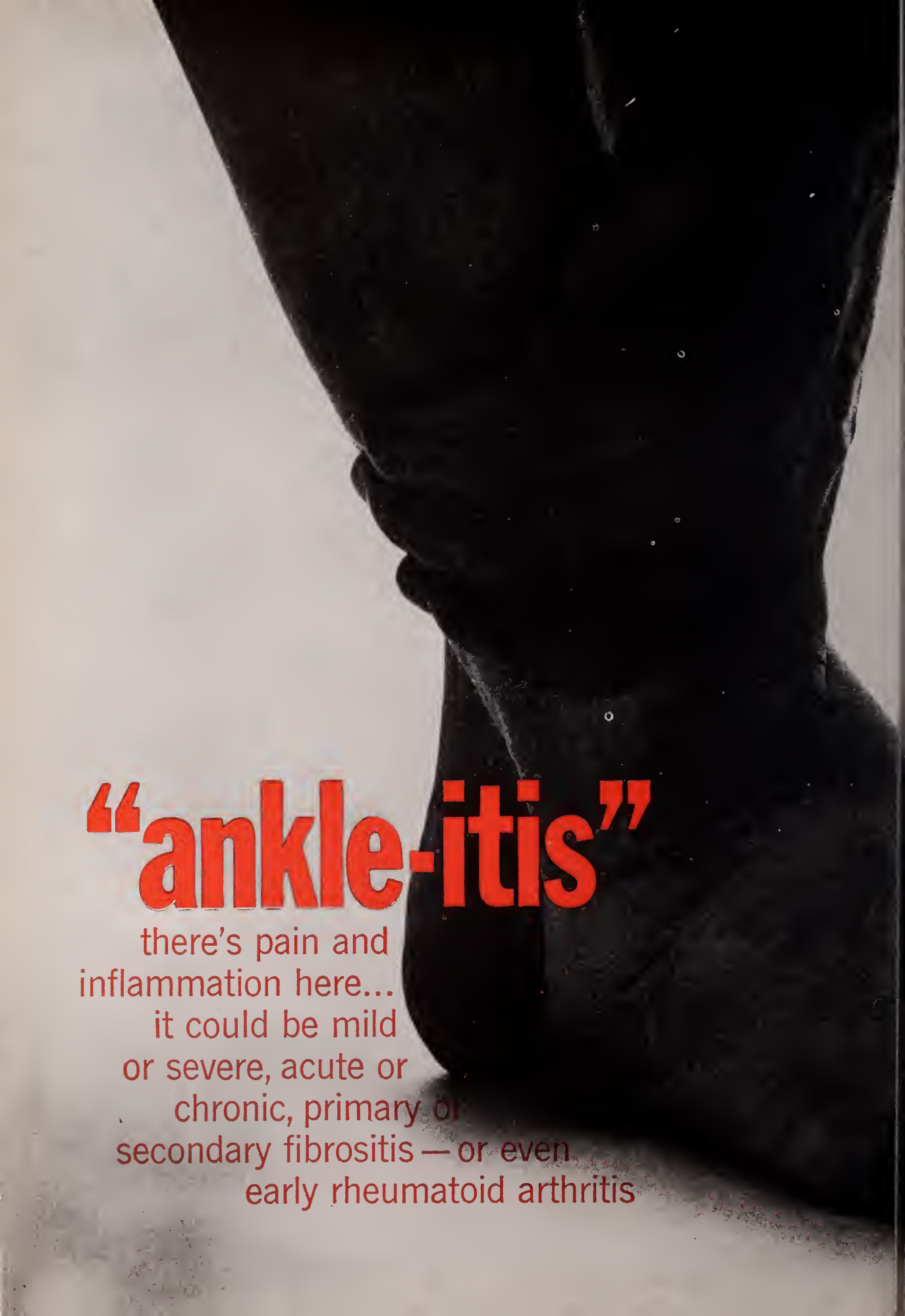
Apr. 7–9: Postgraduate course in endocrinology in pediatrics, UW Medical Center, Madison.

May 3–5: SMS annual meeting, Milwaukee.

May 19–20: Postgraduate course in health aspects of air pollution, UW Medical Center, Madison.

June 23: Teaching program on the heart and lung, for AAGP members, other interested physicans, Madison.

Note: Wisconsin specialty groups, medical schools, hospitals, and paramedical associations are invited to submit a list of their forthcoming meetings or courses for this calendar. Deadline for copy is first of month prior to month of publication. Address communications to: Wisconsin Medical Journal, Box 1109, Madison 1, Wisconsin.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there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary or
secondary fibrositis — or even
early rheumatoid arthritis

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assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

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acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

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Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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UW Postgraduate Course

A postgraduate course on "Fractures in General Practice" will be held on November 12 and 13 at the University of Wisconsin Medical Center under the direction of Dr. Herman W. Wirka. This course will emphasize the practical aspects of the treatment of fractures by various methods. Differentiation of the fracture problem in children and adults will be considered. The faculty will include visiting speakers. Registration may be made with Dr. Robert C. Parkin, Coordinator of Postgraduate Education, 418 North Randall Avenue, Madison 6, Wisconsin.

Symposium in Philadelphia

Deborah Hospital announces the Second International Symposium on Changing Concepts in Medicine (Congenital Heart Disease) to be held at the Bellevue-Stratford Hotel in Philadelphia, Pa., on April 28, 29, 30, 1960.

The Symposium is being organized under the direction of a National Committee headed by Doctor Charles P. Bailey, Chairman of the Medical Board of Deborah Hospital. Eminent clinician-educators will lead panel discussions encompassing all aspects of congenital heart conditions and the selection of patients for surgical corrections.

Inquiries about the Symposium should be addressed to: Dr. Charles P. Bailey, The Deborah Hospital, Browns Mills, New Jersey.

Forthcoming Meetings of WMA

World Medical Association meetings are scheduled as follows:

Feb. 22–Mar. 5, 1960: 12th International Committee for Scientific Management, Sydney/Melbourne, Australia.

Apr. 4–7, 1960: 34th International Anesthesia Research Society Congress, Washington, D. C.

Apr. 20–24, 1960: 6th Congress, Association of European and Mediterranean Societies of Gastroenterology, Leiden, Netherlands.

Fourth National Cancer Conference

"Changing Concepts Concerning Cancer" will be the theme for the fourth national cancer conference sponsored by the American Cancer Society, Inc. and the National Cancer Institute. The conference will be held September 13–15, 1960 at Minneapolis, Minnesota.

For further information write: Medical Affairs Department, American Cancer Society, 521 West 57 Street, New York 19, N. Y.

Anticancer Drug Research Conference

The U. S. Public Health Service's Cancer Chemotherapy National Service Center will hold a two-day conference on clinical anticancer drug research in Washington, D.C., on November 11–12. Participating in the meeting will be many of the nation's leading investigators in cancer chemotherapy.

According to plans being formulated, the meeting will be held at the Hotel Statler and will be open to the press. Approximately 1,000 physicians and scientists are expected to attend.

The principal subject under discussion will be the clinical research being carried out as a part of the program of the Cancer Chemotherapy National Service Center. In addition, speakers have been invited to present papers on other phases of the chemotherapy program, such as, screening for anticancer activity, synthesis and pharmacology of potential anticancer agents, radiation and surgery as adjuvants to chemotherapy, and anticancer drug research abroad.

Dr. B. H. Morrison, III, of the Service Center staff, National Cancer Institute, Bethesda 14, Maryland, is in charge of arrangements for the conference.

Doctor Rogers Lectures Set

Dr. Richard Langendorf, research associate, department of medicine, Michael Reese hospital in Chicago, will be guest lecturer at the ninth annual Dr. Malcolm F. Rogers lectures. The annual lectureship, sponsored by the Wisconsin Heart Association in cooperation with Marquette University and the University of Wisconsin medical schools, is scheduled for November 18–19 in Milwaukee and Madison.

In Milwaukee, November 18, Doctor Langendorf will speak to physicians on "Newer Aspects of Heart Block." The lecture will be held at 8 p.m. in Marquette University medical school, 561 N. 15th St.

In Madison, November 19, plans call for a 4 p.m. convocation for medical students. Doctor Langendorf will discuss "Basic Physiology Demonstrated by Clinical Electrocardiography: Differential Diagnosis of Bigeminal Rhythm." The lecture will be repeated at 8 p.m. for physicians in Bardeen auditorium at the medical school.

The Malcolm Rogers lectures are arranged each year with eminent physicians as guest speakers by the Wisconsin Heart Association as part of its medical education program. Doctor Langendorf's lecture is the third in a series on cardiac arrhythmias. Plans call for the publication of these lectures.

The lectures are open to medical students, residents and physicians.

Other Dates to Remember

Nov. 5–7: Southwestern Medical Association 41st annual meeting, New Mexico Chapter, American Academy of General Practice, Roswell, New Mexico.

ANNOUNCEMENTS

American Board of Obstetrics and Gynecology

The Part I Examinations of the American Board of Obstetrics and Gynecology, are to be held in various parts of the United States and Canada, on Friday, January 16, 1960, at 2:00 P.M.

Candidates notified of their eligibility to participate in Part I must submit their case abstracts within thirty days of notification of eligibility. No candidate may take the Written Examination unless the case abstracts have been received in the office of the Secretary.

Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office: Robert L. Faulkner, M.D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

New Booklet on Epilepsy Available Free

A new booklet on epilepsy has just been published by the Federal Association for Epilepsy here.

Available, free of charge, the booklet was written especially for the Association by Dr. Virginia A. Duggins, a member of the staff of the Department of Neurology and Neurological Surgery, George Washington University School of Medicine here. The publication entitled "Epilepsy—Its Causes, Effects and Treatment" is designed to give the epileptic, his family and friends an understanding of the condition and advice about treatment.

For a free copy, write to the Association at 1729 F Street, N. W., Washington, D. C. Ask for the booklet by name.

Chest Physicians Essay Contest

The American College of Chest Physicians is offering three cash awards to winners of the 1960 Prize Essay Contest. First prize, $500; second prize, $300; third prize, $200. Each winner will also receive a certificate.

The Contest is open to *undergraduate* medical students throughout the world. Essays may be written on any phase of the diagnosis and treatment of chest diseases (cardiovascular or pulmonary). Contest closes on April 1, 1960.

For application and further information, please write: American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

New Scientific Activities Division for SAMA

The Student American Medical Association, the world's largest independent association of resident physicians, interns, and medical students, has just established a Division of Scientific Activities. The announcement was made by Russell F. Staudacher, Executive Director of the Association, after the recent meeting of the Association's Executive Council.

"First Director of the Division will be Dr. Edward R. Pinckney, who is Medical Editor of the association's official publication, *The New Physician*," said Mr. Staudacher. "One of the activities that will be undertaken will be the study of state medical licensing problems as they affect the new physicians," Mr. Staudacher went on to say, "and a panel discussion under the direction of Dr. Stiles Ezell, Secretary of the Board of State Medical Examiners, has already been planned for the May, 1960, annual meeting in Los Angeles."

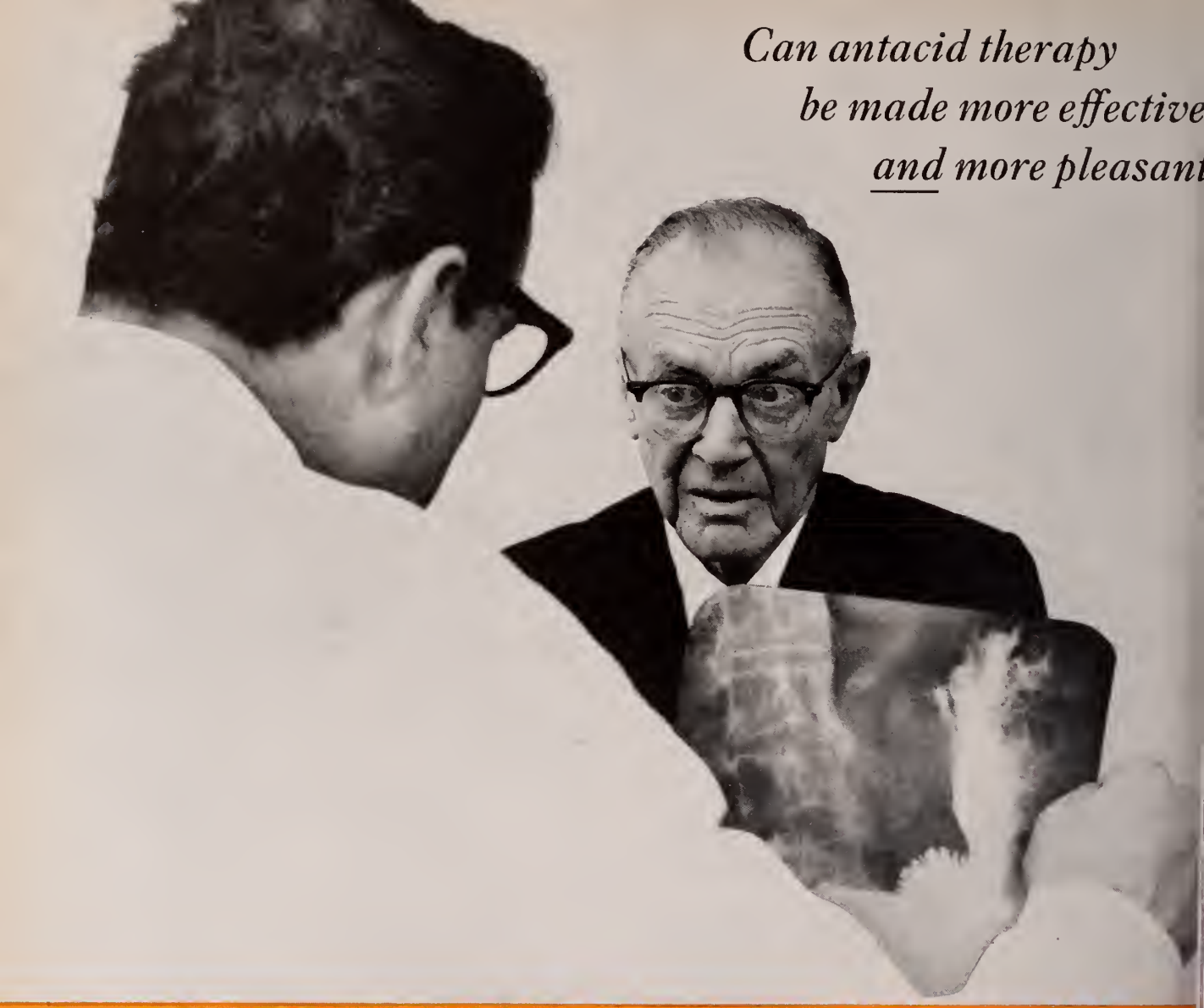
While most of the future projects will depend on grants, Doctor Pinckney told of a study now under way at the request of the United States Senate. "We have been asked to assist the Senate's nonpartisan international health work by making a survey of foreign nationals who are studying medicine, or are working in hospitals, in the United States," Doctor Pinckney said. "The idea is to see if there are any particular difficulties that might be overcome for those from other countries, and to find more ways of making medicine the international diplomatic force it should be."

Other fields to be explored are the study and survey of existing audio-visual aids and exhibits in the medical field; a study of the social environment of the medical student, especially the married student; to see if there are any problems peculiar to those studying medicine; and the increased participation in research by medical students and house physicians.

Because operating costs and activities will depend upon grants, a special grants committee has been set up. Chairman of this committee is Dr. Chauncey D. Leake, Assistant Dean of Ohio State University Medical School and President-Elect of the American Association for the Advancement of Science.

More on Staph. Bibliography

The National Library of Medicine has just issued a supplement to the bibliography on Staphylococcal Infection. Copies may be obtained at no cost upon request to the: Acquisition Division, National Library of Medicine, Washington 25, D. C.



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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

Schizophrenia. By Manfred Sakel, M.D. Philosophical Library, Inc., 15 East 40th Street, New York 16, N. Y. 1958. 335 pages. Price $5.00.

The late Dr. Manfred Sakel introduced insulin shock therapy for schizophrenia in 1927, and thereby instituted an important milestone in the treatment of schizophrenic patients. This book, published shortly after his death in 1957, presents something of the history of this development, the theoretical ideas and prejudices of the author, and importantly, offers a kind of insight into the psychological make-up of this dedicated "advocate" of the "biological approach" in psychiatry.

Frequently dogmatic in the extreme, Doctor Sakel was thoroughly convinced that much of psychiatry had deviated from scientific and biological principle. He often chides the "dynamic" psychiatrists for not "respecting their limitations". In general, he regards the investigations into the "non-biological" aspects of man's existence with a kind of casual tolerance. For example, of a Freudian idea about the nature of paranoid delusions, Sakel writes, "This and other speculations are interesting but they do not contribute anything to the search and understanding of the cause of the basic disease process. They help to understand the deep psychological human factors, but this is as far as they go."

Doctor Sakel deals with "deep psychological human factors" summarily in his thinking and writing. He has a tendency to "bracket," to remove from consideration such "factors" with an explanation which often essentially names some biological term. He brackets the matter of sexuality thusly, "The memory of past experiences of the possibility of the heightening of pleasure by heightening of general tension will lead some individuals who are incapable of being satisfied with the normal sex process and at the same time are not disciplined enough to limit their pleasure to resort consciously or automatically to "adjuvants" to heighten their tension and thus their pleasurable experience by masochistic or sadistic procedures. This appears to be all there is to it."

His need to "bracket" the deeply psychological seems in the traditon of Jessen's explanations of dreams offered 100 years earlier. "Every dimly heard noise produces corresponding dream pictures. The sound of thunder immediately places us in the midst of battle, the crow of a cock may change into the scream of a panic stricken man, the creaking of a door may cause a dream of a burglary", or of Strumpel who explained the typical dream of flying as the image used by the psyche to represent the physical sensation caused by the rise and fall of the dreamer's lung.

The author's exposition of his own theoretical ideas are marked by the imperative and the definitive. "Because of the proven effectiveness of the physiological approach to the disease schizophrenia, it can be assumed that the schizophrenic disease process is based entirely upon a physiological and communicative electrono-ionic disturbance, even though we are not yet capable of proving it by visible clinical or electrical tests." Such phrases as "this seems to offer conclusive proof . . .", and, "having established . . . beyond any possibility of doubt" are liberally sprinkled throughout the book.

However, if dogmatic, if arbitary, if a trifle intolerant, if at times superficial and naive, Doctor Sakel's book represents the thinking of a man whose fundamental contribution was meaningful, forwarding to his profession and of much benefit to mankind. Perhaps what he did speaks louder than what he said.—MILTON MILLER, M.D.

Anatomy for Surgeons; Volume III: The Back and Limbs. By W. Henry Hollinshead, Ph.D., Professor of Anatomy, Mayo Foundation, University of Minnesota, Head of the Section of Anatomy, Mayo Clinic, Rochester, Minnesota. Paul B. Hoeber, Inc., 49 East 33rd Street, New York 16, N.Y. 1958. 901 pages. 785 illustrations. Price: $23.50.

Anatomy for Surgeons is a singularly well-organized work. This book represents the last of three volumes and is confined to a discussion of the back and extremities. It is introduced by a general consideration of the skeletal system, the musculotendinous apparatus, the neurovascular network and skin, with an excellent survey of the developmental anatomy, the changes associated with disease, age, and disuse, and the processes of physiological repair.

The descriptions are straightforward and uncommonly readable due to the author's style and the double column format with boldly headed subsections. Throughout, the author describes the anatomical changes which produce the clinical problems arising in the various areas of the back and extremities, and continually refers to the literature for the authority. He successfully avoids introducing the controversial area of treatment but gives the foundation upon which the surgeon must base his therapy.

The text is profusely supplemented with illustrations which are pertinent and usually diagrammatic. The bibliography is complete and refers to the recent literature. This is an excellent book and can be highly recommended.—HENRY OKAGAKI, M.D.

(continued)

Atrial Arrhythmias, Digitalis and Potassium. By Bernard Lown, M.D. and Harold D. Levine, M.D. Landsberger Medical Books, Inc., New York. 1958. 222 pages.

Simply, the authors fairly conclusively tie in the rather unusual electrocardiographic phenomenon of paroxysmal auricular tachycardia with block with the toxic manifestations of digitalis and thus implicate the potassium balance of the body in the reactivity of the heart to digitalis. They correctly insinuate that in the present day management of heart failure, the negative sodium balance often causes potassium depletion and generalized electrolyte derangement in the body thus changing digitalis sensitivity. There are many effective short case presentations illustrating the main theorem and the electrocardiographic evidence is well documented.

Of interest to the research minded is the chapter entitled "Experiment, Speculation and Hypothesis" which, bearing in mind the possible fallacy of animal and human extrapalation still suggests an effective link between theory and practice.

This is a good book to peruse by all physicians since most of us use and abuse digitalis literature, and are forever amazed by its idiosyncracies.—HERMAN SHAPIRO, M.D.

Clinical Obstetrics & Gynecology. A quarterly book series. Symposium on Genital Cancer, edited by Daniel G. Morton, M.D. Symposium on Operative Obstetrics, edited by J. Robert Willson, M.D. Paul B. Hoeber, Inc., 49 East 33 St., New York 16, N.Y. December 1958. 1138 pages. Subscription price: $18.00/year.

Thus far the editors of Clinical Obstetrics and Gynecology have maintained most admirably the high standards of interest, clinical applicability, scientific insight and literary presentation set in the first issues. One wonders how long suitable topics for such symposia can be found, but as yet there is no sign that the obstetric and gynecologic lode is becoming exhausted. The two topics covered in the present issue are both of considerable interest and the inevitable minor degrees of overlapping by the many authors involved has, so far, proved more of interest in expressing varied and sometimes divergent viewpoints than redundant.

Operative Obstetrics is presented from the viewpoint of trauma and its prevention. The anatomy and pathology of pelvic obstetric injury is graphically portrayed. Medial lateral episiotomy is illustrated which seems somewhat at variance with current practice. The techniques of repair are well pictured and discussed. Dystocia is nicely presented and the section on Forceps Delivery is an excellent current summary. This reviewer was happy to note that Duhrssen's incisions may again be mentioned in polite society. For rotations the author (Savage) prefers a single application technique using Tucker McLane instruments, and he makes the method sound attractively easy. Cosgrove's review of the vast Margaret Hague Cesarean Section experience was most interesting—meticulous technique and a low transverse approach have certainly cut morbidity. The author is not totally adamant regarding the inevitability of repeat Cesarean section. Barter's paper on Operations to Preserve Pregnancy is timely. We would disagree only with the statement that "patients treated surgically for cervical incompetence are best delivered by Cesarean section"—division of the suture near term appears simpler to us.

The tremendous subject of *Genital Cancer* could at best be superficially summarized in the alloted space, and in general, Morton's symposium accomplishes this very well. Diagnosis, treatment, and complications are nicely presented and the importance of early diagnosis is re-emphasized in the paper by Traut. Basic Radiation Therapy is presented by three masters (Schmitz, Sherman and Allen), as is the newer surgical approach (Meigs). This reviewer felt that Meigs' article stressed the niceties of surgical technique a bit too heavily. Also, in such a review I should have been tempted to omit rarities such as tubal malignancy. Everett's summary of his large experience with Complications during the Treatment of Pelvic Cancer was most enjoyable; his experience roughly paralleled ours at University Hospitals, the morbidity most frequently being due to injuries of the urinary tract. As Everett says, "Even when irradiation therapy is administered slowly by a carefully planned technique, urinary tract and intestinal complications cannot always be avoided."

In general, this reviewer felt that the cancer symposium, though very readable, suffered somewhat from the almost inevitable tendency to become too specific and too detailed in what was of necessity a very brief resumé.—WILLIAM KIEKHOFER, M.D.

NEW BOOKS RECEIVED

A Doctor Discusses Menopause. By G. Lombard Kelly, A.B., B.S. MED., M.D., President Emeritus and formerly Professor of Anatomy, Medical College of Georgia; formerly Research Associate in Anatomy, Cornell University Medical School; member American Association of Anatomists; contributor to scientific journals in the fields of Physiology and Endocrinology. The Budlong Press, 5428 North Virginia Avenue, Chicago 25, Illinois. 1959. 90 pages. Pamphlet. Price: $1.50.

American and Foreign Periodicals in the fields of Physical Science, Natural Science, Medicine, Engineering and Technology. Catalogue 95. Walter J. Johnson, Inc. 111 Fifth Avenue, New York 3, New York. 1959. 212 pages.

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LETTERS OF INTEREST

"March of Medicine" Marches on to More Horizons

Dear Doctor Parkin:

Sorry I did not get to talk to you the last time I was in Madison because we did appreciate the spot on your MARCH OF MEDICINE program. There have been some kind remarks and I am amazed at the number of people who follow your program.

If you have no objections, I would like to make the two programs available to Kent University Tape Repository. I would also like to suggest that they consider your whole series for health education. I'm satisfied that your program is one of the best in the country.

H. G. GREWE, D.D.S.
504 Union National
Bank Building
Eau Claire, Wisconsin

Dear Doctor Grewe:

Thank you very much for your interesting letter. I am delighted to know that you have already had a response to the programs that we did together for the MARCH OF MEDICINE. I, too, am continually amazed at the number of people who listen to this program and I am delighted that we could make our "audience" available for the excellent programs that the two of us did together.

I certainly have no objections to you using the tapes to send to the Kent University Tape Repository. I am sure that if they like the programs, and wish further information they will get in contact with me.

If at any time in the future we can assist you in any way, please let me know. It was a pleasure working with you, and I hope that some day we may do it again.

ROBERT C. PARKIN, M.D.
Director

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Clarence S. Livingood, M. D., Detroit, Mich.
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GASTROENTEROLOGY

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INTERNAL MEDICINE

Peter C. Gazes, M. D., Charleston, S. C.
INTERNAL MEDICINE

Donald D. Matson, M. D., Boston, Mass.
NEUROSURGERY

Frank R. Lock, M. D., Winston-Salem, N. C.
OBSTETRICS

Trygve Gundersen, M. D., Boston, Mass.
OPHTHALMOLOGY

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OTOLARYNGOLOGY

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PATHOLOGY

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David G. Pugh, M. D., Rochester, Minn.
RADIOLOGY

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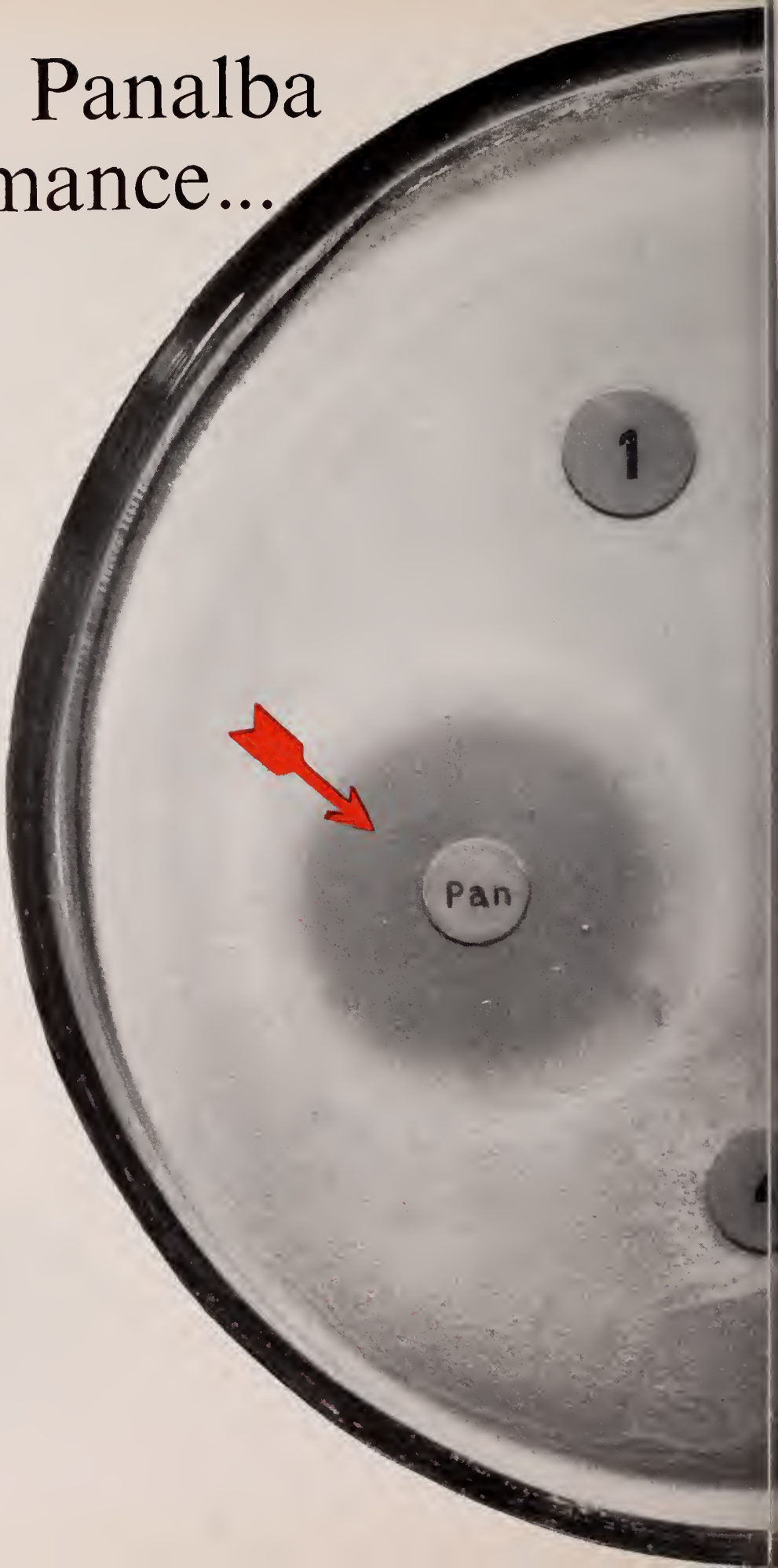

County Society Proceedings

DANE

New officers of the Dane County Medical Society are as follows:

President: *Dr. Frederic E. Mohs*

President-elect: *Dr. C. W. Stoops, Jr.*

Vice-president: *Dr. R. A. Straughn*

Secretary-treasurer: *Dr. A. P. Schoenenberger*

Health Officer: *Dr. C. K. Kincaid*

Delegates: *Drs. E. J. Nordby, L. E. Holmgren, P. B. Golden,* and *W. T. Russell*

Alternates: *Drs. H. M. Suckle,* R. A. Straughn, A. P. Schoenenberger, and *V. W. Nordholm*

Election of officers was held at the annual meeting on October 13 at State Society headquarters.

Other matters handled at the annual meeting were the passing of a resolution of appreciation to the Woman's Auxiliary for their pictorial gift to the State Medical Society and the passing of a motion to encourage the present practice of immunization in the office of private physicians and in the county nurse's office for people who cannot afford private care, thus assuring availability to all citizens within the county.

DODGE

The Beaver Dam Medical Forum met on Monday evening, October 19. The business meeting was conducted by the president, *Dr. R. I. Bender* and a financial report and an outline of the coming years activities were presented by the secretary, *Dr. W. G. Richards.* The speaker of the evening was *Dr. R. E. Urbanek* who presented a paper on endometriosis. Doctor Urbanek reviewed the theories and etiology of endometriosis and brought the members up-to-date on the latest methods of therapy.

FOND DU LAC

On September 24, the Fond du Lac County Medical Society met at the Elks Club in Fond du Lac for a business session. Matters discussed were the need for a very active public policy committee in the future, the feasibility of engaging an attorney to represent the society, and the possibility of raising county dues for the coming year. Also, the following physicians were elected to take office on January 1, 1960:

H. R. Sharpe, Jr.—President

R. W. Schroeder—Vice President

C. M. Flanagan—Secretary–Treasurer

R. S. Pelton—Delegate

D. J. Twohig—Alternate Delegate

Dr. L. A. Hoffman was appointed to a three-year term on the board of censors.

JEFFERSON

Mr. Earl Thayer, assistant secretary of the State Medical Society, addressed the Jefferson County Medical Society on the activities of the State Medical Society during the past year at a meeting held September 17 at the Jefferson Country Club.

During the business meeting *Dr. R. W. Quandt* reported on the delegates' meeting, the resignation of *Dr. E. J. Netzow* as Medical Director for Jefferson County was read, and a committee was appointed to meet with the County Board to settle difficulties.

POLK

On September 17, the Polk County Medical Society and Auxiliary met at Forestwood Resort in Frederic as dinner guests of *Dr.* and Mrs. *R. M. Moore.* Thirty-five were present.

Dr. Howard Shaw, a Minneapolis, Minnesota, ophthalmologist, spoke to the group on "Common Ophthalmologic Problems of the General Practitioner." A round table discussion followed the talk.

PIERCE–ST. CROIX

Members of the Pierce-St. Croix County Medical Society met on the evening of September 15. The Dibbo Hotel at Hudson was the site of their meeting.

RICHLAND

The Richland County Medical Society met October 1 in Richland Center—first for dinner at the Park Hotel and later at the Richland Hospital.

Dr. H. H. Shapiro, Madison, lectured on "Electrocardiographic Tracings" and *Dr. C. E. Hopkins,* also of Madison, discussed the use of digitalis in pediatrics.

(continued)

Physicians whose names appear in italic are members of the Society.

It was announced at the meeting that civil defense films will be shown in two weeks.

WAUKESHA

Dr. A. R. Curreri, professor of surgery and director of cancer research at University Hospitals, Madison, was guest speaker at the September 2 meeting of the Waukesha County Medical Society. He addressed the members at the Oconomowoc Lake Club.

WINNEBAGO

The Winnebago County Medical Society met September 10 at the American Legion Club in Oshkosh. The main item of business on the agenda was adoption of a new constitution.

WOOD

"Extrauterine Pregnancy" was the topic chosen by *Dr. A. W. Hulme*, Wisconsin Rapids, when he spoke before the Wood County Medical Society September 10 at Casa Loma, Marshfield. Also discussing the subject was *Dr. R. F. Lewis* of Marshfield.

Dr. G. H. Williams was appointed as coordinator for civil defense at the business meeting.

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Milwaukee Oto-Ophthalmic Society

Dr. Harvey E. Thorpe, Chairman of the Department of Ophthalmology, Montifiore Hospital, Pittsburgh, Pennsylvania, was guest lecturer at the November 24 meeting of the Milwaukee Oto-Ophthalmic Society. His subject was on "Intra-ocular foreign bodies."

The next meeting of the Society will be held on January 26, 1960, at which time the guest lecturer will be Dr. William F. Hughes, Chairman of the Department of Ophthalmology, Presbyterian–St. Luke's Hospital, Clinical Professor of Ophthalmology, University of Illinois College of Medicine, Chicago, Illinois. His subject will be "The Corneal Dystrophies, Diseases of the Cornea and Corneal Transplantations."

Wisconsin Academy of General Practice

Beginning September 20, the Wisconsin Academy of General Practice held their 11th Annual three-day assembly in Milwaukee. Lecturers discussed the late scientific and medical advances of interest to the family physician.

Wisconsin Dermatology Society

A joint meeting of the Wisconsin and Minnesota Dermatology Societies was held in Marshfield September 12. The scientific portion of the session, held at the Marshfield Clinic, featured observation and examination of patients with various skin ailments, and discussions on the different cases by the physicians.

A dinner at the Hotel Charles was attended by the members and their wives in the evening. Mr. Ken Hultgren, treasurer and comptroller of the Roddis Plywood Corporation, was after-dinner speaker.

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

The following program was presented to members of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology when they met at Eagle Waters Resort, Eagle River:

Saturday, September 12

"Symposium on Eye"
Dr. D. P. Hornbogen, Moderator
"Alpha-chymo-trypsin in Cataract Surgery"
"Anesthesia in Cataract Surgery"
D. P. Hornbogen, M. D.
Marquette, Michigan
Fred C. Sabin, M. D.
Marquette, Michigan
V. Lepisto, M. D.
Hancock, Michigan
Hugh McEachran, M. D.
Iron Mountain, Michigan
"Movie on Alpha-chymo-trypsin"
—Alcon Company

Sunday, September 13

"Symposium on Ear, Nose and Throat"
Dr. John Russell, Moderator
"Facial Fractures"
Hugh McEachran, M. D.
Iron Mountain, Michigan
John Russell, M. D.
Appleton
"Audiology"
W. B. Larkin, M. D.
Marshfield
A. M. Kinkella, M. D.
Marshfield
Kenneth Pollock, M. S.
Marshfield

In addition to the scientific sessions, a business meeting and dinner were held.

Wisconsin Society of Internal Medicine

—Marshfield News Herald Photo

Pictured above are four past presidents of the Wisconsin Society of Internal Medicine. These physicians received awards in recognition of their services to the medical specialists' organization which held its annual meeting September 19 in Marshfield. They are, left to right: Dr. Karl H. Doege, Marshfield, president in 1957; Dr. Robin N. Allin, Madison, 1958; Dr. J. LeRoy Sims, Madison, 1959, and Dr. Paul G. LaBissoniere, Milwaukee, president for the coming year.

Wisconsin Society of Plastic Surgery

It was recently announced that *Dr. Frank Bernard*, professor of surgery at the University of Wisconsin Medical School, was elected to the board of directors of the Wisconsin Society of Plastic Surgery. This society was organized last January.

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Wisconsin Radiological Society

The 10th Annual Meeting of the Wisconsin Radiological Society was held at the Milwaukee Inn, Milwaukee, September 11–13. The scientific sessions featured the following lectures: "Epidemic Pulmonary Histoplasmosis—Roentgenographic Findings" by *Dr. D. P. Babbitt*, Milwaukee; "Pulmonary Embolism and Acute Cor Pulmonale with Emphasis on Roentgen Diagnosis" by Dr. Felix G. Flieschner, Boston, Massachusetts; "A New Roentgenographic Method of Fetal Weight Determination—Preliminary Report" by *Dr. S. A. Marks*, Milwaukee; "The Place of Cobalt^{60} Teletherapy in Radiotherapeutic Practice" by Dr. D. G. Mosser, Minneapolis, Minnesota; "Combined Radiotherapy and Chemotherapy in Cancer" by *Dr. Halvor Vermund*, Madison; and "A New Oral Cholangiographic Method" by *Dr. H. G. Bayley, Jr.*, Beaver Dam. A movie entitled "Radiation; Physician and Patient," filmed by the American College of Radiology, was discussed by *Dr. J. Edwin Habbe*, Milwaukee.

During the business meeting the following officers were elected for the coming year:

President: *Dr. Robert W. Byrne*, Milwaukee

President-elect: *Dr. Farrell F. Golden*, Madison

Secretary–Treasurer: *Dr. Howard G. Bayley*, Beaver Dam

Board of Directors: *Dr. Herbert M. Aitken*, Eau Claire; *Dr. Leslie E. Jones*, Racine; *Dr. Eugene Betlach*, Janesville; *Dr. Donald P. Babbitt*, Milwaukee; *Dr. Morris Moel*, Milwaukee; *Dr. Theodore J. Pfeffer*, Milwaukee

Councilor to the American College of Radiology: *Dr. Irving I. Cowan*, Milwaukee

Alternate Councilor: *Dr. Ralph C. Frank*, Eau Claire

Wisconsin Surgical Society

The Wisconsin Surgical Society, at their semi-annual meeting held in Oshkosh on September 19, honored *Dr. F. Gregory Connell* of Oshkosh, first president of the Society in 1946, for his many services rendered to the medical profession as a whole in addition to his work with their group. The tribute was paid him at a dinner held at the American Legion Clubhouse. Principal speaker was Dr. O. T. Clagett of the Mayo Clinic, Rochester, Minnesota.

Preceding the dinner, scientific sessions were presented at Mercy Hospital. The morning meetings were sponsored by Fox River Valley physicians, with the members at large presiding over the afternoon program.

Scientific papers presented were as follows:

"Post-traumatic Pancreatic Pseudocyst" by *Dr. Thomas E. Lynn*, Green Bay, (sponsored by Dr. L. D. Quigley); "Nutritional Status of Patient Following Massive Small Bowel Resection" by *Dr. Wil-*

(continued)

liam Dafoe, Appleton; "Pheochromocytoma, a Case Report" by *Dr. Gordon H. Hardie*, Neenah, (sponsored by Dr. L. D. Graber); "Esophageal Reconstruction with Colon" by *Dr. Ernest Zmolek*, Oshkosh; "Hormones and the Treatment of Metastatic Breast Carcinoma" by *Dr. L. D. Graber*, Oshkosh; "Study of the Use of Metal Fascial Clips" by *Dr. Harvey Sharpe, Jr.* and *Dr. Norman O. Becker*, Fond du Lac; "A Follow-up on Cholecystectomies Performed in the Absence of Cholelithiasis" by *Dr. J. W. McRoberts*, Sheboygan; and "Study of the Accuracy of Oral Cholecystography" by *Dr. Howard Mauthe*, Radiologist, St. Agnes Hospital, Fond du Lac, (sponsored by Dr. N. O. Becker). Dr. Louis D. Graber, chairman of the Fox River Valley Section presided at this morning session.

Presiding at the afternoon session was *Dr. James M. Sullivan*, president of the Society. The following papers were presented:

"Adductor Muscle Injuries in Bowlers" by *Dr. James R. Hoen*, Sheboygan; "The Treatment of Varicose Ulcers" by Dr. James M. Sullivan, Milwaukee; "Local Anesthesia" by *Dr. William B. Gallagher*, La Crosse; "Postoperative Care of Respiratory, Poor Risk, Surgical Patients" by Dr. William C. Gorman, Veterans Administration Hospital, Wood; "Simultaneous Occurrence of Perforation and Massive Hemorrhage in Duodenal Ulcer" by *Dr. John R. Steeper*, Madison; and " Volvulus of the Sigmoid Colon"; by *Dr. Ben R. Lawton* and *Dr. George Williams* (by invitation), Marshfield.

Doctor Clagett's address in the evening was entitled, "Current Status of the Problem of Breast Carcinoma."

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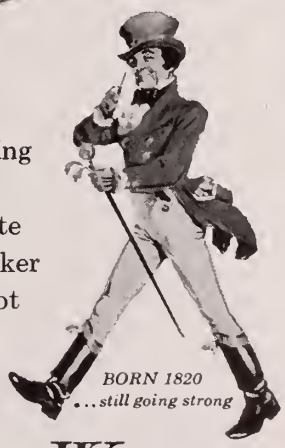

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News of Wisconsin Physicians

Doctor Theiler Practices in Green Bay

An obstetrician and gynecologist, Dr. George J. Theiler, has become affiliated with the Gosin–Lynn Clinic of Green Bay. Doctor Theiler came to Green Bay from Fort Rucker, Alabama, where he had spent two years as chief of the obstetric-gynecologic department at the base hospital.

Previously he had graduated from the University of Wisconsin, interned at Milwaukee County General Hospital, and served his residency both there and at Milwaukee Hospital.

Watertown Gets New Doctor

A 1958 graduate of the University of Illinois, Dr. R. C. Baldwin, has located in Watertown. Prior to opening his office for general practice he interned at Cook County Hospital, Chicago.

Doctor Gundersen Moderates Workshop

The American Association of Medical Clinics chose *Dr. Gunnar A. Gundersen* of La Crosse as moderator of a workshop on medical records. The Association, whose members are comprised of physicians from the United States and Canada who practice medicine as members of a group or clinic, held their 10th Annual Meeting in Chicago, September 24–26.

Dr. Marshall Speaks to Writers' Group

Dr. Wallace Marshall, Watertown, spoke on "How to Make Medical Articles Interesting," at the sixteenth annual meeting of the American Medical writers' Association held October 2 in St. Louis, Mo. Doctor Marshall is book review editor of the Mississippi Valley Medical Journal.

Scientific Exhibitors

Scientific exhibitors at the 24th annual meeting of the Mississippi Valley Medical Society held September 29–October 1 in St. Louis, Mo., included:

Raymond F. Grenfell, M. D., and James G. Hilton, Ph.D., Jackson, Miss., and Milwaukee, of the University of Mississippi Medical Center and Marquette University School of Medicine. Their exhibit was entitled "Treatment of Essential Hypertension (A Double-blind Study)."

James K. Martins, M. D., and Mrs. James K. Martins, Eau Claire. Their exhibits title was, "The Role of the General Practitioner in Clinical Investigation."

Doctor Gillespie Released from Service

Dr. C. J. Gillespie has returned to his native city of Antigo to practice with *Dr. B. W. Beattie* after serving with the U. S. Air Force at Mitchell Air Force Base, Long Island, New York. Doctor Gillespie graduated from Marquette University in 1956 and entered service the month following completion of his internship at Evangelical Deaconess Hospital in Milwaukee.

Doctor Peterson Associates with Freeman Group

A 1958 graduate of the University of Wisconsin, Dr. Thomas H. Peterson, recently became affiliated with the Freeman Medical Group, Wausau. Doctor Peterson interned at St. Mary's Hospital, Madison, and during the past summer was practicing in Wausau on a temporary basis before joining the group.

Dr. James Leahy Moves to Nebraska

Dr. James J. Leahy has left his Park Falls practice to join the Physicians Clinic at Omaha, Nebraska. Doctor Leahy had been associated with his father since 1948 when he was discharged from service with the U. S. Army. He previously had graduated from the Northwestern University Medical School in 1945 and interned at Milwaukee County Hospital.

Doctor Bruhn Practices in Walworth

It was recently announced that a native of Milwaukee, Dr. Irwin J. Bruhn, opened an office at Walworth. Doctor Bruhn received his medical training at the University of Wisconsin, graduating in 1958, and completed an internship at Rockford Memorial Hospital, Rockford, Illinois, June 30.

Shell Lake Clinic Adds Member

Dr. D. L. Flogstad joined the Shell Lake Clinic in late August. He recently completed two years with the U. S. Army, being stationed at Fort Bliss, Texas. A graduate of the University of Minnesota School of Medicine, Doctor Flogstad interned at St. Mary's Hospital, Duluth.

Four Named to Medical Board

In mid-September Governor Gaylord Nelson appointed four doctors to the State Board of Medical Examiners. They include *Drs. Gunnar A. Gundersen*, La Crosse; *Thomas Henney*, Portage; and *Irvin L. Slotnik*, Milwaukee. Also *Dr. Thomas W. Tormey, Jr.*, Madison, was renamed to the office of secretary.

The new nominees succeed *Drs. Jerry McRoberts*, Sheboygan; *Ewald Pawsat*, Fond du Lac; and *Fordyce Ross*, Milwaukee.

Doctor Fink Locates at St. Croix Falls

Having recently been discharged from the U. S. Army, Dr. D. W. Fink has affiliated with the St.

(continued)

Physicians whose names appear in italic are members of the Society.

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NEWS OF PHYSICIANS (continued)

Cro'x Falls Clinic, thus bringing their total to seven staff members. While in the military Doctor Fink was stationed at Fort Hood, Texas.

Doctor Fink graduated from the University of Wisconsin Medical School in 1956 and interned at Miller Hospital, Minneapolis, Minnesota. He is a former resident of Sparta.

Doctor Krohn Named Fellow

During a recent five-day meeting of the International College of Surgeons, it was announced that *Dr. Robert Krohn* of Black River Falls had been elected a qualified fellow of the College. Doctor Krohn had traveled to Chicago for the meetings.

Hypnotism Talk Given

On September 14 *Dr. V. J. Taugher* of Berlin spoke in Oshkosh before the members of the Nursery Guild of St. John's Evangelical Lutheran Church. His lecture covered the history and use of hypnotism used in medicine, especially in its relationship to childbirth.

Medical Clinic Opens in Valders

Dr. W. E. Acheson, Valders, held open house September 12 for the public to view his new medical office building. The construction features blond paneling in the waiting room, business office and hallway; two private offices; four complete examining rooms; an emergency surgery room; an x-ray room; and a laboratory. The building is air conditioned and has an intercommunication system over which soft music is played.

Simultaneously, Doctor Acheson announced the association of Dr. R. L. James for the general practice of medicine and surgery. Doctor James recently returned from Germany where he served as battalion surgeon for the U. S. Army Second A. C. Regiment.

Silver Anniversary Marked by Doctor Zenner

On August 25 *Dr. Clarence E. Zenner* marked his 25th anniversary as a practitioning physician in Cadott. Upon completion of his medical training at Marquette University, an internship at Milwaukee County General Hospital, and a year of residency at Milwaukee General and Milwaukee County Emergency Hospitals, Doctor Zenner came immediately to Cadott. Now associated with him at the Cadott Medical Center, which was built in 1952, are *Drs. B. J. Haines* and Clifford T. Bowe.

THIRD AND TWELFTH DISTRICTS

Dr. Joyce Kline Joins Madison Radiologist

It was announced in August that *Dr. Joyce Kline* is associated with *Dr. Wayne Rounds,* director of the department of radiology at St. Mary's Hospital, Madison. The physicians are now located in the office of the late Dr. L. V. Littig and have purchased his equipment.

(continued)

Doctor Kline graduated from the University of Wisconsin Medical School in 1954. She interned at Michael Reese Hospital in Chicago, served one year of an internal medicine residency at St. Mary's Hospital, Madison, and completed a three-year residency in radiology at Wisconsin General Hospital in June of 1959.

Urologist Added to Beloit Clinic

Dr. J. C. Beltran, a graduate of the University of Zaragoza Medical School, Spain, and the son of a physician, is now affiliated with the Beloit Clinic in the department of urology. Doctor Beltran took one year of postgraduate work in Spain before coming to the United States for additional studies. He served a rotating internship at Doctors Hospital, Cleveland, Ohio, and took urologic residencies at St. Joseph's Hospital, Lexington, Kentucky, and Homer G. Phillips Hospital, St. Louis, Missouri. Since that time he had been in the field of research, working on kidney transplantation. His paper on the project was read at the last convention of the American Urology Association at Atlantic City and was awarded second prize.

Doctor Cooper Heads Health Panel

Dr. G. A. Cooper, assistant professor at the University of Wisconsin Medical School and a diplomate of the American Board of Dermatology, has been appointed chairman of the health panel of the Community Welfare Council. He has served for two terms on the board of directors of the Council which is an agency of the United Community Chest.

Doctor Reese Back from Japan

In August *Dr. Hans Reese* returned to Madison from a five-month stay in Japan, three of which were spent at Fukuoka City. While there he taught at the Kyushu University and did research on the frequency and clinical variation of multiple sclerosis in Japan.

During the last six weeks he lectured at the Universities of Tokyo, Niigata and Hokkaido and visited places of interest.

Monroe Clinic Gets New Doctor

A La Crosse native, Dr. James Stormont, has joined the internal medicine department of the Monroe Clinic. Doctor Stormont came to Monroe from Rochester, Minnesota, where he had been assistant to staff in medicine at the Mayo Clinic since completion of his fellowship there in October, 1958. Previously he graduated in 1954 from medical school at George Washington University and interned at Miller Hospital, St. Paul. He served in the U. S. Navy during World War II.

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Dr. Lucille Glicklick Accepts CP Post

Dr. Lucille B. Glicklick, Milwaukee, has been named medical director of the cerebral palsy clinic of The Medical Society of Milwaukee County. She succeeds Dr. Neil R. Thomson, who resigned.

Doctor Glicklick was a 1950 graduate of the University of Wisconsin Medical School and served a pediatric residency at Milwaukee Children's Hospital. She taught pediatrics for a year at the University of Illinois and has been an instructor at Marquette University since 1957.

Dr. Joseph Shaiken Elected to Office

Dr. Joseph Shaiken of Milwaukee was installed as president of the American College of Gastroenterology at the organization's 24th Convention which was held at the Biltmore Hospital, Los Angeles, California. The organization has a membership of nearly 900 specialists in gastroenterology or related specialties.

Two Madison Physicians Delegates

Drs. Robin N. Allin and *Charles W. Crumpton,* both of Madison, attended the annual meeting and scientific sessions of the American Heart Association as delegates. The meetings were held in Philadelphia, Pennsylvania, October 23–27.

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Dr. Hartridge Joins Jackson Clinic

Dr. T. L. Hartridge has joined the staff of the Jackson Clinic, Madison, in the ear, nose and throat department. A native of Milwaukee and Oconomowoc, he received the degree of M. D. from the University of Pennsylvania in 1934, which was followed by a two-year rotating internship at Philadelphia General Hospital from 1934 to 1936. He opened an office for the general practice of medicine in Horicon, leaving after two years to enter the U. S. Army.

Dr. Hartridge

In his 20 years of active military service Doctor Hartridge served in many installations, both in the United States and Europe. During World War II he was in combat service as part of General Patton's Third Army. In 1946 he returned to Wisconsin to command the Station Hospital at Camp McCoy.

Deciding to specialize in otolaryngology, Doctor Hartridge completed a two-year fellowship and residency at Washington University, by July 1949. After several years of additional training at Murphy General Hospital, Boston, and at the Station Hospital, Fort Benning, Georgia, he became a Diplomate of the American Board of Otolaryngology. He was elected a Fellow of the American Academy of Ophthalmology and Otolaryngology in 1956 and in 1958 was elected a Fellow of the American College of Surgeons. His special interest in the field of otolaryngology is in otology and deafness in children.

Doctor Peckham Honored

The Centennial Merit Award was presented to *Dr. B. M. Peckham,* chairman of the department of obstetrics and gynecology at the University of Wisconsin Medical School, designating him as one of Northwestern University Medical School's distinguished alumni. The award was received at ceremonies marking the school's centennial. He is one of twenty recipients of this citation given for outstanding work in academic medicine.

A 1942 graduate of the medical school at Northwestern, Doctor Peckham obtained a master of science degree in 1947 and doctor of philosophy in 1949. He came to the University of Wisconsin in 1956 from practice in Chicago, Illinois.

New Officers in Physical Medicine

Two Milwaukee physicians have recently been elected 1959–60 officers in the American Academy of Physical Medicine and Rehabilitation. *Dr. Ray Piaskoski* is the new president-elect and *Dr. Robert W. Boyle* is the new vice-president.

(continued)

Speak at ACOG Meeting

Drs. F. Jackson Stoddard, Frederick J. Hofmeister and *William P. Wendt*, Milwaukee, were authors of a paper presented at the District VI meeting of the American College of Obstetricians and Gynecologists held October 16–17 at Omaha, Nebraska. The paper was entitled, "Procedures to Combat the Incompetent Cervix—A Critical Evaluation." Doctor Hofmeister is district chairman.

At Nursing Home Convention

Dr. Carl N. Neupert, state health officer, was a member of a panel which discussed "Our Relations with Nursing Homes" at the annual convention of the American Nursing Home Association held in Chicago October 6–9.

Dr. Jackson Receives Honors

Dr. Arnold S. Jackson, Madison, was presented a Fellowship by the American Medical Writers' Association at its sixteenth annual meeting in St. Louis, Mo., on October 2. Doctor Jackson received the honor "in recognition of high qualifications, personal and professional, and of established standing as a medical writer, journalist, or publisher."

Postgraduate Clinic in Madison

Preceding the Wisconsin–Marquette football game, the 29th annual postgraduate program sponsored by Marquette University School of Medicine and the Jackson Clinic, was held at Methodist Hospital, Madison.

Clinic physicians who participated in the program were *Drs. George Ewell* talking on kidney stones, Robert Wheatley discussing cytologic diagnosis of cervical disease, Theodore Hartridge speaking on the treatment of ear disease, and a panel of *Luther Holmgren, William Waskow* and *William Parsons. Dr. Arnold S. Jackson* moderated their discussion on prevention and management of complication of abdominal surgery.

The three Marquette University staff members who lectured were *Drs. Donald Ruch* on skin manifestations of internal disease, *Anthony Pisciotta* on blood reactions to various drugs and *Donald Roth* on the selection and preparation of twins for kidney transplant.

Surgical College Accepts Two Madisonians

Drs. John T. Phelan and *James F. McIntosh*, both of Madison, were inducted as new fellows of the American College of Surgeons at Atlantic City, New Jersey, October 2. Doctor Phelan is an instructor at the University of Wisconsin Medical School, while Doctor McIntosh has a private urological practice.

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Dr. Arnold Jackson Honored

Dr. Arnold S. Jackson, director of the Jackson Clinic and chief of staff of Methodist Hospital in Madison, was made an honorary fellow of the International College of Surgeons at its meeting in Chicago in mid-September. He was chosen along with 10 other distinguished surgeons in the world to receive the honor because of their contribution to surgical progress.

Doctor Samp Talks

On September 22 *Dr. Robert J. Samp* of the University of Wisconsin Medical School addressed a joint meeting of the Racine and the Lakeland Industrial Safety Councils held at Burlington. The theme of the program centered around the idea of the health, safety and welfare of top management, foremen and supervisors.

Doctor Coyne Moves to Pennsylvania

Dr. John F. Coyne left Janesville in mid-August to accept a post for the Transformer Division of Westinghouse Electric Corporation, Sharon, Pennsylvania. He had been medical director of the Janesville Fisher Body and Chevrolet plants since 1956, coming there from Fond du Lac where he had had a general practice.

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Dr. Lester McGary Retires

Dr. Lester McGary, who has been the pathologist at Madison General Hospital for the past 33 years, has retired as of November 1, 1959. He became the Emeritus Pathologist at that hospital three years ago when *Dr. Philip G. Piper* was appointed Director of Laboratories. Doctor McGary was honored not only by the Madison General Hospital Association at their yearly meeting, but also by the Medical Staff at a testimonial dinner in his honor for his many years of service.

—Photo by Tom Barlet, Capital Times, Madison

Dr. Lester McGary

Doctor Piper will continue on as Director of Laboratories. He is a Diplomate of the American Boards of Anatomical and Clinical Pathology, a Fellow of the American Society of Clinical Pathologists, a member of the American College of Pathologists, the International Academy of Pathology, and the Wisconsin Society of Pathologists. He is also an Assistant Clinical Professor of Pathology in the University of Wisconsin Medical School.

Former students and employees who had served during the past 36 years under *Dr. Lester McGary*, honored him at a special dinner August 29. A leather bound volume of personal letters describing memorable events from their school days was presented to him by the students.

Following graduation from Tulane University Medical School, Doctor McGary became Madison General's first resident pathologist in 1923. He founded the school of medical technology at the hospital in 1926.

Named Medical Director

Dr. Merrill P. Benoit has been appointed medical director at AC Spark Plug, the Electronics Division of General Motors.

Doctor Benoit, who brings with him a distinguished record in industrial medicine, formerly held the post of plant physician at Delco-Remy, another GM division in Anderson, Indiana, for the past 10 years.

Doctor Benoit is a graduate of Tufts Medical College, Boston, Mass.

What's New at the Medical Schools

Respiratory and Rehabilitation Center

JoAnn Ulvestad, her arms paralyzed by polio, is a typical patient who will be helped at the newly opened Respiratory and Rehabilitation Center at the University of Wisconsin Medical Center. The 17-year-old Madison girl uses her unparalyzed muscles to control the "artificial muscle," a device that

—University of Wisconsin Photolob Photo

JoAnn Ulvestad demonstrates her "artificial muscle" to Governor Gaylord Nelson, right, while William Engel watches.

works by compressed carbon dioxide. William Engel, of the Center staff, makes functional braces such as the one used by JoAnn.

Other patients from throughout Wisconsin—victims of any severely disabling disease or injury—may be referred to the Center by their physician. The Center is aimed at restoring patients such as JoAnn to their greatest possible physical, mental, social and vocational potential. Staff teamwork applies a broad range of evaluation or "total patient care" to each case.

Teaching and research are other functions of the Center, directed by Dr. Arthur Siebens with Dr. Theodore Bruns as assistant director. The Center, one of 15 similar institutions in the nation, is aided by grants from such organizations as the National Foundation and the Sister Elizabeth Kenny Foundation.

Grants Received

Marquette University School of Medicine has received research grants totalling $323,096.59, teaching grants totalling $93,682, and gifts for general educational purposes totalling $6,750 for the period June 12, 1959 to September 18, 1959. The announcement was made at the quarterly meeting of the Board of Directors. The grants were dispersed as follows: Research, $328,096.59; training grants of $40,517 for graduate work, $12,960 for a senior research fellowship, $40,000 for teaching, and $205 for scholarships; gifts for general educational purposes totalled $6,750.

Dr. Randall Gives Addresses

The November guest speaker of the Milwaukee Academy of Medicine, Henry T. Randall, M. D., addressed the students of Marquette University School of Medicine on Tuesday, November 17 at the Medical School Auditorium. Doctor Randall spoke on "Research in surgery as it pertains to the cancer problem."

Doctor Randall is Clinical Director and Chairman of the Department of Surgery, Memorial Center for Cancer and Allied Diseases, and Professor of Surgery at Cornell University School of Medicine. He is currently President of the Society of University Surgeons.

Doctor Randall also addressed the house staff of the Veterans Administration Hospital, Wood, on November 16 on "Oopherectomy, adrenalectomy, and hypophysectomy in the management of recurrent breast cancer." On Tuesday, November 17, he attended the weekly conference at the Milwaukee County Hospital.

Doctor Randall's address to the Milwaukee Academy of Medicine was given on Tuesday evening, November 17, at the University Club. He spoke on "Practical approach to the diagnosis, management, and prevention of the usual electrolyte problem seen in surgical patients."

Dr. Kersting to Speak

David W. Kersting, M. D., Professor and Chairman of the Department of Dermatology at MU School of Medicine, will participate in a postgraduate course on dermatology sponsored by the American Academy of Dermatology and Syphilology to be given at Northwestern University Medical School December 5 and 6. Doctor Kersting will discuss "The pathology of dermal nevi and neoplasms." Doctor Kersting will also be one of five physicians to participate in the main panel of the clinicopathologic

(continued)

conference of the American Academy of Dermatology and Syphilology at its annual meeting at the Palmer House, Chicago, on December 9.

Gives Malcolm Rogers Lecture

Richard G. Langendorf, M. D., attending physician in the Department of Medicine, Michael Reese Hospital, Chicago, and also research associate in the Department of Cardiovascular Disease at the same hospital, was the speaker at the annual Malcolm Rogers lecture sponsored by the Wisconsin Heart Association in cooperation with Marquette University School of Medicine on November 18. Dr. Langendorf spoke on "Newer aspects of heart block."

Three Participate in Chest Physicians Meeting

Three physicians from MU School of Medicine participated in the Silver Anniversary meeting of the American College of Chest Physicians in Albuquerque, New Mexico, October 14–17. They were Andrew L. Banyai, M. D., Clinical Professor of Medicine, Emeritus; John H. Huston, M. D., Assistant Professor of Medicine; and Ross C. Kory, M.D., Associate Professor of Medicine.

Doctor Banyai presented a paper on October 17 on "Applied physiology in the control of cough." Doctor Huston also presented a paper on the same day on Hyperkinetic cardiovascular syndromes." Doctor Kory participated in a round table at a luncheon meeting on October 15 on "Mechanisms of breathing, with special reference to medical and surgical problems." He also participated in a Fireside Conference on "Inhalation therapy: Apparatus and technics."

Med School Ball to Be Held

The annual Med School Ball, sponsored by the Student American Medical Association of Marquette University School of Medicine, will be held December 11 at 8:00 p.m. at the Wisconsin Club. Honored this year will be the *Marquette Medical Review*, the quarterly scientific publication published by the students of the school. The Review is celebrating its 25th anniversary this academic year of 1959–60.

Sixteen Appointed to AOA

Alpha Omega Alpha, the national honorary medical fraternity, has elected 11 seniors and 5 juniors from Marquette to membership. The appointments were approved August 31. Seniors appointed were Edward F. Banaszak, Gary A. Becker, Roland C. Brown, Brian T. Coffey, Joseph E. Geenan, John A. Harris, Michael H. Keelan, John A. Kenny, Jr., John R. Rogers, Andrew E. St. Amand, and Anthony P. Ziebert. Juniors appointed are Paul B. Borgesen, Lee R. Duffner, Adam Fueredi, Guenther T. Pohlmann, and Daniel S. Thearle.

Membership in AOA is based on scholarship, outstanding personality, character, promise of future intellectual attainment and service to the medical profession, and recognized ethical, moral, and religious character. One-sixth of the senior class is eligible to be elected. Automatically, the top five juniors in the class are elected. Present seniors who were appointed automatically as juniors last year are Alan E. Lewis, Clayton A. Feldman, Donald R. Laub, Richard C. Marohn, and Malcolm V. Vye.

William S. Middleton Medical Library Fund Exceeds $400,000 Level

Mr. David Smith, President of the Wausau Paper Mills Co., Brokaw, Wisconsin, in the picture below, presents a $5,000 library fund contribution to Dean John Z. Bowers while visiting the new Rehabilitation Center, University Hospitals.

—University of Wisconsin Photolab Photo

Mr. David Smith and Dean John Z. Bowers

This generous contribution takes the Library Fund total over the $400,000 level.

Interest in medical affairs is natural to Dave Smith since his father was in medical practice for many years in the Wausau area and his son will soon enter the UW Medical School. Dave's father, Dr. Joseph Smith, is a past-president of the State Medical Society of Wisconsin and was for many years a preceptor for the University Medical School.

The site for the Medical Library has been approved by university authorities and work is proceeding on architectural plans. University Medical Alumni hope to bring the campaign to a successful conclusion in the next six months.

(continued)

Doctor Reese Resumes UW Activities

Dr. Hans H. Reese, Department of Neurology, University of Wisconsin Medical School has resumed his activities. He had been appointed by the National Institute of Neurology, Washington, D. C., to continue the geomedical researches on multiple sclerosis and allied diseases in Japan for six months. He was requested also to introduce on a broader basis the neurological sciences, especially the importance of clinical neurology into the curriculum of the medical schools of Japan. After three months of activities at the University of Kyushu he was given an honorary membership by the medical faculty, the first ever given by the university to a foreigner. He addressed the Japan Medical Congress April 1 to 10, and participated as the only foreign doctor in a Symposium of Demyelinizing Diseases at Tokyo. He lectured at the Universities of Sapporo, Niigata, Nagasaki, Kumamoto, Kurume, Hiroshima and Yamaguchi finishing this lecture series with conferences, discussions, and lectures at the University of Tokyo Medical School. In recognition of his services the Medical faculty of the University of Tokyo presented him with their university emblem.

Dr. Jensen Receives Grant

Joerg Jensen, M. D., Associate Professor of Microbiology and Immunology, has received a renewal grant of $4,830 from the United States Public Health Service to study "Biosynthesis of catalase and other hematin enzymes." The grant is for one year, beginning December 1, 1959.

Training Grant Received in Psychiatry

A $15,000 renewal training grant in psychiatry has been received by Marquette University School of Medicine for the period September 1, 1959, to August 31, 1960. Training program director is Eugene S. Turrell, M. D., Professor and Chairman of the Department of Psychiatry.

New Appointment for Doctor Musser

Dr. Marc J. Musser, who was on the teaching staff of the medical school of the University of Wisconsin from 1938 until his appointment to the Houston VA hospital staff in 1957, has been appointed director of professional services at the Houston, Texas, Veterans Administration hospital. In his new position in Washington, D. C., Doctor Musser will coordinate a nationwide program of some 6,000 individual and cooperative studies, with major categories in cancer, heart and blood vessel disease, mental illness, aging, tuberculosis, atomic medicine, and dental research.

Doctor Musser received his medical degree in 1934 from the University of Wisconsin.

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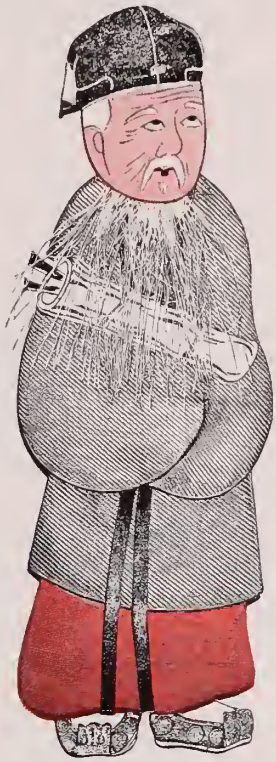

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Obituaries

Dr. H. D. Baird, Montreal, passed away August 24. He was 69 years of age.

Born at Sheridan, Pennsylvania, in 1889, Doctor Baird received his medical degree from the University of Pennsylvania in 1911. Following his internship at Christ Hospital, Jersey City, New Jersey, he opened an office at York, Pennsylvania, where he remained until 1942. He then came to Wisconsin and became associated with the Montreal Clinic.

Doctor Baird was a member of the Ashland–Bayfield–Iron County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American Industrial Medical Association.

Survivors include his widow, Mary; four daughters and a son.

Dr. W. E. Donohue, a Manitowoc general practitioner, died September 6 at the age of 76. He had been ill for the past few years, retiring from practice in 1957.

A native of Wisconsin, Doctor Donohue was born at Two Rivers in 1882. He graduated from medical school at Northwestern University in 1910. Upon completion of his internship at Mercy and St. Anthony's Hospitals in Chicago, Doctor Donohue returned to Wisconsin and settled in Manitowoc.

He served as chairman of the Medical Board of Holy Family Hospital and had started the first laboratory there in his early years of practice. He also held an honorary membership on the staff of Memorial Hospital.

During World War I Doctor Donohue served with the Medical Corps, being stationed at the Red Cross Hospital No. 1 in France and was an examiner for the Selective Service Board.

He was a member of the Manitowoc County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American College of Surgeons. An active member of his county society, for which they honored him in 1958, he had served as president, secretary, and chairman of both the Medical and Membership Committees.

Surviving are his widow, Anita; a son, William, Jr. of Evanston; and a daughter, Mrs. Willott Pitz of Manitowoc.

Dr. A. E. Williams of Fountain City died September 10 at the age of 78.

A native of Blue Mound, having been born there in 1881, Doctor Williams graduated from Marquette University School of Medicine in 1908. He had a wide variety of experiences in the medical profession, practicing in Alaska; Seattle, Washington; Black Diamond, Washington, where he operated his own hospital in the coal mining town; Virginia City, Montana; and Backus, Minnesota. He also worked as a surgeon aboard steamships traveling between Seattle and the Orient before locating in Wisconsin. His practices in this state included those at Boyceville, Alma Center and Fountain City.

Survivors are his widow and two sons.

Dr. Merton Field, a retired Chippewa Falls specialist, died September 17 at the age of 88.

Doctor Field was born at Lewiston, Maine, in 1871. Upon graduation from the University of Minnesota, he located in southern Minnesota where he had a general practice for over twenty years. Doctor Field came to Chippewa Falls in 1925 after completion of postgraduate studies at Harvard Univsity in the field of eye, ear, nose and throat. At the age of 80 he retired.

During his years of Wisconsin practice, Doctor Field was a member of the Chippewa County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the State Society's Fifty Year Club.

He is survived by his widow, two daughters, and two sons.

Dr. J. G. Burden, 41, died unexpectedly September 24. He had been a general practitioner in Milwaukee for the past twelve years.

Doctor Burden was born in 1918 at Traverse City, Michigan. He graduated from the University of Michigan in 1943, interned at Baptist Memorial Hospital at Memphis, Tennessee, and took a year of residency at the Hospital for Special Surgery, New York, in 1945.

A member of the Medical Society of Milwaukee County, he also held memberships in the State Medical Society of Wisconsin and the American Medical Association.

Besides his widow, Doris; a son, Michael; and a brother survive.

Dr. Helvi A. Swanljung, a La Crosse ophthalmologist, succumbed October 1. She was 43 years of age.

Doctor Swanljung was born at Helsinki, Finland, in 1916. A 1946 graduate of the University of Helsinki, she had studied in London, at a number of hospitals in Finland, at Johns Hopkins Hospital in Baltimore, Maryland, and was a research fellow at the University Hospitals in Iowa City, Iowa. From 1939 to 1942 her medical studies were interrupted when she served with the Finnish army. The doctor came to La Crosse from Finland in 1957 and joined the Gundersen Clinic and the staff of Lutheran Hospital.

Doctor Swanljung was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

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Medical Meetings - Postgraduate Courses

Minnesota Postgraduate Courses

Medical continuation courses to be presented at the center for continuation study, University of Minnesota, are as follows:

Jan. 11–13, 1960: Ophthalmology for Specialists

Jan. 21–23, 1960: Surgery for Surgeons

Feb. 8–10, 1960: Cardiovascular Diseases for General Physicians and Specialists

Feb. 15–19, 1960: Pediatric Neurology for Specialists

New Orleans Medical Assembly

The twenty-third annual meeting of The New Orleans Graduate Medical Assembly will be held March 7, 8, 9, and 10, 1960, headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-six informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical cruise on the M/S Franca "C" to the West Indies, leaving from Port Everglades, Florida, on Saturday, March 12. The itinerary includes visits to Puerto Rico, Virgin Islands, Martinique, Barbados, Trinidad, Curacao and Haiti, returning to Florida on Friday, March 25.

Details of the New Orleans meeting and the cruise are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

International College of Angiology

The International College of Angiology will hold its first regional meeting in the Hotel Continental, Mexico City, Mexico, December 29–30, 1959. The scientific program will consist of 20 papers being presented by distinguished scientists from North and South America, 4 round-table breakfasts and luncheons. The annual "honors night" banquet will be held the evening of December 29 and among the guest speakers will be Dr. Fernando Monterel, Professor of Surgery, University of Madrid, Spain.

The scientific sessions will cover the areas of arterial occlusive disease and thrombo-embolic phenomena. Following the meeting there will be two planning conferences in Acapulco under the joint auspices of The Angiology Research Foundation and The International College of Angiology.

(continued)

WISCONSIN CALENDAR COMING EVENTS

1960

Jan. 19: Circuit teaching program, Vernon County Memorial Hospital, Viroqua.

Jan. 20: Circuit teaching program, Waupun Memorial Hospital, Waupun.

Jan. 21: Circuit teaching program, Elks Club, Appleton.

Jan. 21–22: Midwinter Safety Conference, Wisconsin State Board of Health, Milwaukee.

Jan. 26: Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

Feb. 11–12: Postgraduate course, Laboratory Diagnosis for General Practitioners, UW Medical Center, Madison.

Feb. 18: Postgraduate course in therapeutics, UW Medical Center, Madison.

Feb. 23: Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

Mar. 10–12: Postgraduate course in neurological problems, UW Medical Center, Madison.

Mar. 22: Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

Apr. 7–9: Postgraduate course in endocrinology in pediatrics, UW Medical Center, Madison.

Apr. 28: Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

May 3–5: SMS annual meeting, Milwaukee.

May 19–20: Postgraduate course in health aspects of air pollution, UW Medical Center, Madison.

May 26: Annual meeting, Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

June 23: Teaching program on the heart and lung, for AAGP members, other interested physicans, Madison.

Note: Wisconsin specialty groups, medical schools, hospitals, and paramedical associations are invited to submit a list of their forthcoming meetings or courses for this calendar. Deadline for copy is first of month prior to month of publication. Address communications to: Wisconsin Medical Journal, Box 1109, Madison 1, Wisconsin.

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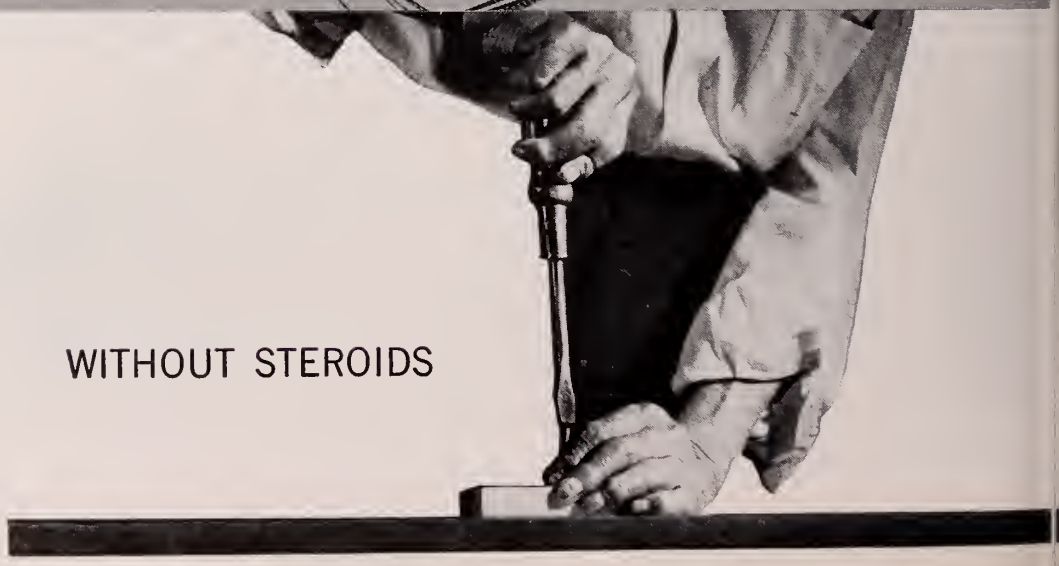

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References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Poliey, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

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MEDICAL MEETINGS (continued)

Dr. Hector Quijano Mendez, Professor Clinical Surgery, National University, Mexico City, is Chairman of the meeting.

A number of special pre- and post-convention tours have been planned by the Committee.

Information and travel arrangements may be obtained by writing to Mr. Joseph Tigani, Committee For Travel and Housing, 150 East 50th Street, New York City.

National Society for Crippled Children and Adults

More than a thousand professional staff members, administrators and volunteers working with the crippled at Easter Seal centers throughout the nation will seek solutions to their problems when they attend the 1959 annual convention of the National Society for Crippled Children and Adults, Nov. 29–Dec. 3, at Chicago's Palmer House.

"Searching Out Solutions," the convention theme, will feature top flight specialists working in the field of the handicapped who will help solve perplexing problems pertaining to the care, treatment and rehabilitation of crippled children and adults. General sessions, institutes, workshops and symposiums are planned for the five-day meeting.

In response to numerous requests for working sessions integrating board members, other volunteers and staff, this year's convention will highlight problems in administration, care and treatment, organization, public relations and fund raising.

Outstanding speakers and discussion leaders who have been scheduled for the Easter Seal convention include Roy Campanella, the Los Angeles Dodgers' wheelchair catching coach who served as sports chairman in 1959 for the Easter Seal campaign; Chloe Gifford, president of the General Federation of Women's Clubs; Dr. Robert J. Samp, assistant professor of the department of surgery at the University of Wisconsin Hospitals, Madison; Mrs. Theodore O. Wedel, nationally known civic leader and professional church worker.

World Medical Association Meetings

Feb. 22–Mar. 5, 1960: 12th International Committee for Scientific Management, Sydney/Melbourne, Australia.

Apr. 4–7, 1960: 34th International Anesthesia Research Society Congress, Washington, D. C.

Apr. 20–24, 1960: 6th Congress, Association of European and Mediterranean Societies of Gastroenterology, Leiden, The Netherlands.

May 23–28, 1960: Asian–Pacific Congress of Cardiology, Melbourne, Australia.

July 25–29, 1960: International Congress of Occupational Health, New York, New York.

Sept. 16–22, 1960: XIVth General Assembly of The World Medical Association, West Berlin, Germany.

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Announcing THE TWENTY-THIRD ANNUAL MEETING OF

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DERMATOLOGY

Henry D. Janowitz, M. D., New York, N. Y.
GASTROENTEROLOGY

John G. Walsh, M. D., Sacramento, Calif.
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Donald D. Matson, M. D., Boston, Mass.
NEUROSURGERY

Frank R. Lock, M. D., Winston–Salem, N. C.
OBSTETRICS

Trygve Gundersen, M. D., Boston, Mass.
OPHTHALMOLOGY

Carroll B. Larson, M. D., Iowa City, Ia
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PATHOLOGY

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For information concerning the Assembly meeting and the cruise write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

LETTERS OF INTEREST

Editor's Note: Doctor Zubren refers to a news release of the State Medical Society's Charitable, Educational and Scientific Foundation concerning an athletic injuries clinic held in Eau Claire on October 8, 1959. The news release cited statistics of the Wisconsin Interscholastic Athletic Association which reported payments for nearly 7,000 injuries as a result of athletic accidents. Many of these were extremely minor. More than 500 dental injuries for which benefits were paid through WIAA benefit plans resulted in claims totalling $14,333.20. Additional details are available from the WIAA office in Stevens Point.

To Dr. R. S. Baldwin:

A recent article, Oct. 7, 1959, entitled: "Athletics Injure 7,000," reprinted State Medical Society figures based on insurance claims. The article was printed in the *Milwaukee Journal.*

The inexperienced young high school football player who is well protected is understandably prone or susceptible to some of the injuries such as sprains, lacerations, etc. The dental claims and concussions can be reduced to a minimum by advocating a necessary protective device, mouth protectors. Surveys in the Philadelphia Public high schools and Kansas City Public high schools indicate that when a mouth protector is used, concussions and dental injuries are completely eliminated 100%. These studies have been reprinted in the dental literature and are available.

I would appreciate the State Medical Society figures and the cost of the insurance claims if this record is available. The dental profession must be awakened to its responsibility for these disfiguring, painful and costly dental injuries.

LOUIS ZUBREN, D.D.S.
5500 W. Capitol Drive
Milwaukee 16, Wisconsin

To Doctor Parkin:

I listened to "March of Medicine" with especial interest today (No. 528, Tetanus). I'm one of your "captive audience," an engineer at WHKW, near Chilton. Your programs are usually interesting, but this one especially so, as proper immunization is one of my pet subjects to preach upon. You see, I saw a man die of tetanus during the war, and I have seen the results of little, or no immunization in the pockmarked faces of people all over Europe. I have also seen the size of their graveyards. I might be a timid character in this matter of avoiding disease by preventing it, but isn't it well worth the discomfort of a couple of shots to stay alive and healthy?

You have a problem staring you in the face: First, educate your colleagues not to "pooh-pooh" the patient coming in for a complete immunization and booster schedule. Teach them to teach their patients that these steps are darned good and darned cheap insurance. Secondly, start an educational campaign towards getting the public to demand proper immunization. Because we rarely hear of smallpox these days, is that any reason not to be vaccinated against it? By the way, how long is a vaccination "good"? When should it be repeated? How about the polio series, when should they be boosted or repeated? I get my tetanus booster every year or so. I don't bother my good friend Dr. Bill Dafoe very much—I'm the healthy type, I guess. Bill believes in proper and regular immunization, probably because he has a baseball team of kids of his own. Few other MD's do, though, and even fewer will bother to preach at their patients about it. Sure, give the kids all the shots—and Ma and Pa's vaccinations are 20 years old!

Why not a campaign towards making the public aware of the need for renewal of their immunization shots taken long ago? It seems to me that this is a matter of prime importance to Civil Defense people. Epidemics are likely after large-scale destruction of water and sewer facilities, but can probably be minimized by the proper immunization of large segments of the public beforehand. Why isn't some effort made in this direction? It seems mighty important to me!

I enjoy your programs; they usually are quite interesting and enlightening. Very well done, they're in English, not technicalese, and they get your information across painlessly. Few radio programs can make that statement!

F. C. HERVEY
Rt. 3 (Quinney)
Chilton, Wisconsin

* * *

To SMS:

On behalf of the Sunrise 4-H Club and myself, I wish to express our hearty thanks for rewarding our Sunrise 4-H with your twelve issues of "Today's Health" magazine published by your American Medical Association and presented to us by the best wishes of State Medical Society of Wisconsin.

This magazine is greatly enjoyed by the members and leaders. "Health" is one of the 4-H's we as 4-H'ers strive for in our every day living.

Thank you.

VIDAS HERTER
Sunrise 4-H
217½ Wisconsin Street
New London, Wisconsin

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Thanks to your treatment and the help of Deprol, her depression is relieved and her anxiety and tension calmed. She eats well, sleeps well, and can return to her normal activities.

County Society Proceedings

DANE

The November meeting of the Dane County Medical Society was held on the 10th of the month at the Bardeen Auditorium located in the University of Wisconsin Medical School. *Dr. John Z. Bowers*, Dean of the Medical School, introduced the guest speaker, Dr. Arthur Siebens, director of the Rehabilitation Center at the University Hospitals, Madison, who explained the scope of his activities, his future plans and described the present establishment. He expressed the need to bring disabled people to gainful employment and help make their lives meaningful. Following the discussion, the members were invited to visit the Rehabilitation Center located in University Hospitals where a demonstration was given of equipment in actual use by patients with respiratory deficiencies due to poliomyelitis.

DODGE

The Beaver Dam Medical Forum met on Monday evening, November 16, after a business meeting during which an out-of-town guest speaker for the February meeting was selected. *Dr. R. I. Bender* gave a brief discussion regarding his recent attendance at the November meeting of the Interstate Postgraduate Medical Association of North America meeting in Chicago, Illinois. The speaker of the evening, *Dr. William G. Richards*, presented a paper on the "Common Benign Skin Tumors." He briefly reviewed the embryology and histology of the skin and then reviewed the common benign tumors of the skin using descriptive photomicrographs.

DOOR-KEWAUNEE

On September 17 the Door-Kewaunee County Medical Society held a joint annual meeting with the Brown County Medical Society and the Brown and Door-Kewaunee Counties Bar Associations at the Leathern-Smith Lodge in Sturgeon Bay. A social hour and golf preceded the dinner where Attorney Robert B. Murphy of Madison spoke on "Some of the Common Interests of the Medical and Legal Professions." Ninety lawyers and physicians attended.

The Door-Kewaunee County Medical Society met October 27 at the Stebbins Hotel in Algoma. During the program *Dr. H. J. Kief*, Sixth District Councilor, presented a report and Messrs. P. R. Doege and Ray Koenig of the State Medical Society office in Madison led a round-table discussion of Wisconsin Physicians Service insurance plans. Following this an A.M.A. film strip, "Time of Decision", was shown and a recording of remarks by A.M.A. president, Dr. L. M. Orr, was heard.

Physicians whose names appear in italic are members of the Society.

FOND DU LAC

"Don't be Rash with the Rash Problem" was the topic of *Dr. Donald Ruch's* lecture delivered at the October 22 meeting of the Fond du Lac County Medical Society held at the Elks Club in Fond du Lac. Doctor Ruch, a Milwaukee dermatologist, showed slides to augment his talk at the dinner meeting. He was introduced by *Dr. M. R. Vrtilek.*

During the business session, the members approved a recommendation that the County Society donate $200 to the Charitable, Educational and Scientific Foundation of the State Medical Society.

LANGLADE

The Langlade County Medical Society met November 9 at the Langlade County Memorial Hospital in Antigo. Guest speaker was *Dr. Sherburne F. Morgan*, pediatrician at Milwaukee Children's Hospital Cardiac Clinic. His talk, "Rheumatic Fever in Childhood", was sponsored by the Wisconsin Heart Association in cooperation with the State Medical Society.

OCONTO

Dr. Herman H. Shapiro, associate clinical professor of medicine at the University of Wisconsin Medical School, lectured, under the sponsorship of the Wisconsin Heart Association, at the October 20 meeting of the Oconto County Medical Society held at the Lilac Club near Gillett. His talk was entitled "Coronary Disease, Its Peculiarities."

PIERCE-ST. CROIX

The Pierce-St. Croix County Medical Society met October 20 at the Hotel Walvern in River Falls. Their November 17 meeting was held at Marcel's between New Richmond and Somerset.

POLK

Members of the Polk County Medical Society met as dinner guests of *Dr. Lewis J. Weller*, Osceola, on October 15 at the Dalles House in St. Croix Falls. An obstetrician and gynecologist from Minneapolis, Minnesota, Dr. Leonard Lang, presented a paper on endometriosis. Following his talk a round-table discussion was conducted. Also on the program were Mr. C. H. Crownhart, executive secretary of the State Medical Society, and Mr. Robert Murphy, legal consultant to the State Medical Society.

During the business session the following physicians were elected to office for the coming year:

President—*D. M. Ericksen*, M.D.
President-elect—*O. N. Arneson*, M.D.
Secretary-treasurer—*L. J. Weller*, M.D.
Board of Censors—*K. K. Ford*, M.D.

(continued)

On November 19 the Polk County Medical Society met at Paradise Lodge in Balsam Lake as guests of *Dr. Lorne Campbell* of Clear Lake. Guest speaker for the meeting was Dr. A. Falk, St. Paul, medical director of Group Health Plans, who led a discussion on prepaid medical care.

TREMPEALEAU-JACKSON-BUFFALO

The October 27 dinner meeting of the Trempealeau-Jackson-Buffalo County Medical Society held at the Pines Nite Club in Black River Falls featured *Dr. H. H. Shapiro,* Madison, as guest speaker. He lectured on "Coronary Artery Disease." No business meeting was held.

The Club Midway in Independence was the site of the meeting of the Trempealeau-Jackson-Buffalo County Medical Society on November 24. Main item of business at the annual meeting was the election of officers. Those chosen were: *Drs. J. R. Marks,* Black River Falls, president; *J. S. Tschetter,* Whitehall, president-elect; *J. H. Noble,* Black River Falls, secretary-treasurer; *E. P. Rohde,* Galesville, delegate; *W. E. Wright,* Mondovi, alternate delegate; *O. M. Schneider,* Blair, public relations; and *C. B. Moen,* Galesville, board of censors. Those held over on the board of censors are *Drs. M. O. Bachhuber* of Alma and *Robert Krohn* of Black River Falls.

COUNTY SOCIETY SECRETARIES
SPECIALTY SOCIETY SECRETARIES

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Milwaukee Academy of Medicine

On October 20 the Milwaukee Academy of Medicine met at the University Club of Milwaukee for dinner and a scientific program. Guest lecturer was Dr. Paul Kotin from the department of pathology at the University of Southern California School of Medicine. He spoke on "The Role and Action of Environmental Agents in the Pathogenesis of Pulmonary Cancer: A Laboratory-Clinical Study." Doctor Kotin is presently on sabbatical leave at the McArdle Memorial Laboratory, the University of Wisconsin Medical School.

Milwaukee Oto-Ophthalmic Society

Because the scheduled speaker for the November 24 meeting of the Milwaukee Oto-Ophthalmic Society was unable to be in Milwaukee on that specified date, the resident staff of the Veterans Administration Hospital at Wood and the Milwaukee County Hospital furnished the program. Dr. Edward Kronschnable, senior resident in otolaryngology at Wood, presented a film named "Laryngeal Surgery." Dr. Ingrid Raits, senior resident in ophthalmology at Milwaukee County General Hospital, read a paper on "Experience with Two New Anticholinesterase Agents in the Difficult to Control Glaucoma Patient." The agents were Echothiophate (phospholine iodide) and Bc-48 (Humorsol).

Physicians whose names appear in italic are members of the Society.

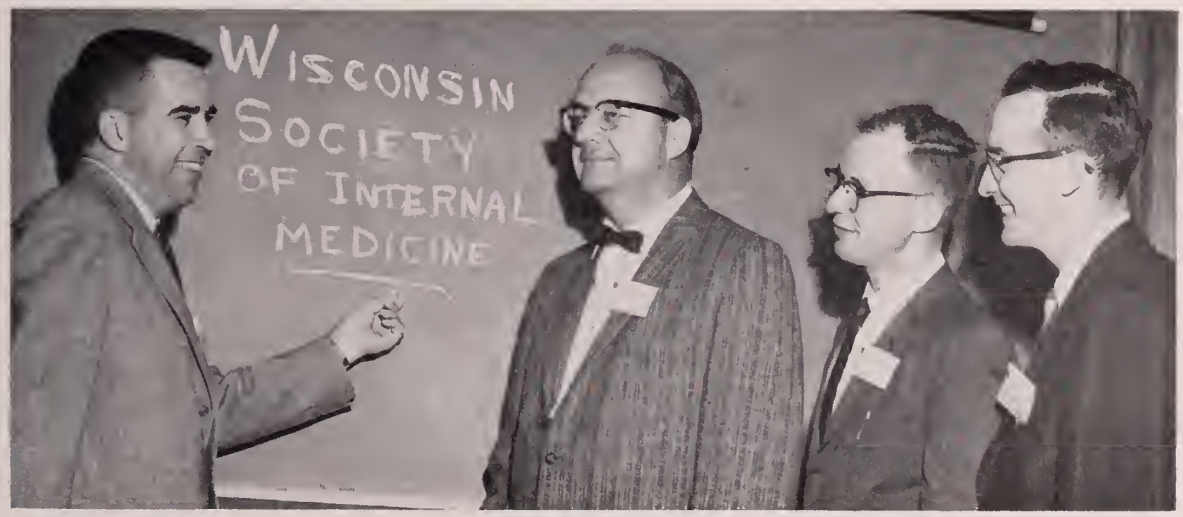
Wisconsin Academy of General Practice

The Wisconsin Academy of General Practice presented a program in Green Bay on October 13 at

Green Bay Press-Gazette Photo

Speakers at the Wisconsin Academy of General Practice meeting in Green Bay are pictured above, left to right: Dr. Sidney K. Wynn, Marquette University; Dr. David W. Smith, Dr. Robert C. Parkin and Dr. John LeRoy Sims, University of Wisconsin; and Dr. Tiber J. Greenwalt, Marquette University.

Officers Installed at Internists Annual Meeting



Newly installed officers of the Wisconsin Society of Internal Medicine posed for this group picture during the Annual Meeting of the Society, September 29, in Marshfield. Left to right are: Drs. Paul G. LaBissoniere, Milwaukee, president; Robert L. Gilbert, La Crosse, president-elect; George I. Gutmann, Janesville, and Edward K. Ryder, Jr., Madison, were elected to the Council. Not pictured: Drs. Leslie G. Kindschi, Monroe was elected secretary-treasurer; and Dean H. Becker, Jr., Oshkosh, was elected to the Council. Nearly 100 physicians attended the annual meeting which was held at the Marshfield Clinic. The program featured speakers on scientific and economic topics.

(continued)

D. S. Lindberg Photo

Principal speakers at the obstetrical meeting in Marshfield are pictured above, seated left to right: Dr. Roy Holly, Omaha, University of Nebraska; Dr. Fred Hofmeister, Milwaukee, Marquette University; and Dr. Ben Peckham, Madison, University of Wisconsin. All are professors of obstetrics and gynecology in the respective medical schools. Standing are Marshfield obstetricians, Dr. T. J. Rice, who moderated a panel discussion; Dr. R. F. Lewis, president of the Wisconsin Society of Obstetrics and Gynecology; and Dr. J. W. Rupel. Doctor Lewis and Doctor Rupel presented cases for discussion.

St. Vincent Hospital. This was the first in a series of six statewide sessions on recent developments in medicine to be sponsored by the group. The seminar was given expressly for general practitioners in the area, but was open to all members of SMS who wished to attend.

Speakers included *Drs. Sidney K. Wynn* and *T. J. Greenwalt* from Marquette University and *Drs. David W. Smith, R. C. Parkin* and *J. L. Sims* from the University of Wisconsin.

The Wisconsin Academy of General Practice, a chapter of the second largest medical organization in the world, is headed by *Dr. Charles J. Picard*, Superior, who succeeded *Dr. David N. Goldstein*, Kenosha, at the group's annual meeting at Milwaukee in September.

Wisconsin Society of Obstetrics and Gynecology

The annual fall meeting of the Wisconsin Society of Obstetrics and Gynecology was held November 17 at the Marshfield Clinic. Principal speakers were Dr. Roy Holly, Omaha, University of Nebraska; *Dr. Fred Hofmeister*, Milwaukee, Marquette University; and *Dr. Ben Peckham*, Madison, University of Wisconsin. Two local physicians, *Drs. T. J. Rice* and *J. W. Rupel* presented cases for discussion. Doctor Rice also moderated a panel discussion. President of the society, *Dr. R. F. Lewis*, Marshfield, presided at the meeting.

ANNUAL MEETING FEATURES: MAY 3–4–5, 1960

TUESDAY: Special programs on Internal Medicine, Obstetrics and Gynecology, and Pediatrics.

WEDNESDAY: Special programs on General Practice, Pathology, Psychiatry, and Urology.

THURSDAY: Special programs on Anesthesia, Ophthalmology and Otolaryngology, Radiology, and Surgery.

News of Wisconsin Physicians

Physicians Meet in Eau Claire

A joint meeting of the Cancer Detection Clinic and Tenth Councilor District was held December 3 at Sacred Heart Hospital in Eau Claire. The meeting was presented by the Eau Claire County Unit of the Wisconsin Division of the American Cancer Society in cooperation with the Committee on Cancer of the State Medical Society and the Wisconsin Academy of General Practice.

Dr. Richard C. Brown, Eau Claire, program chairman of the Eau Claire County Unit of the American Cancer Society, was moderator of the Clinic. The welcome address was given by *Dr. Ralph C. Frank,* Eau Claire, chairman of the Professional Education Committee of the Wisconsin Division of the American Cancer Society, and Councilor of the Tenth District of the State Medical Society.

The afternoon scientific program included the following:

"Oral Cancer Diagnosis" by *Dr. Robert J. Samp,* assistant professor of surgery, University of Wisconsin Medical School, Madison.

"Cancer of the Lung" by *Dr. Joseph W. Gale,* professor of surgery, University of Wisconsin Medical School, Madison.

"Office Cancer Detection in Gynecology" by *Dr. F. J. Hofmeister,* associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee.

"Cold Cone Biopsy of the Cervix" by *Drs. Harold J. Conlon* and Richard C. Brown, Eau Claire.

"Pre-malignant Lesions of the Rectum and Colon" by *Dr. Gordon V. Marlow,* Madison.

Dr. Robert J. Samp, Madison, was the evening speaker following dinner at the Eau Claire Hotel. His subject was, "Face Up—Speak Up—Shape Up!" Dr. Ralph C. Frank gave a Councilor Report.

Maternal Mortality Institute

Physicians, hospital administrators, obstetrical nurse supervisors, and nurse anesthetists were among those attending the Maternal Mortality Institute held December 10 at St. Vincent's Hospital in Green Bay. The program, one of a series, was sponsored by the State Medical Society, the Wisconsin State Board of Health and the Wisconsin Academy of General Practice.

The scientific program consisted of the following:

"Pelvic Tumors and Ovarian Cysts" by *Dr. F. J. Hofmeister,* Milwaukee.

"Proper and Improper Uses of Blood" by *Dr. William Kiekhofer,* Madison.

"Abnormal Position of the Fetus" by *Dr. T. A. Leonard,* Madison.

"Regional Anesthesia for Increasing Obstetrical Patient Safety" by *Dr. William R. Kreul,* Racine.

Physicians whose names appear in italic are members of the Society.

Doctor Loughnan Retires

Dr. A. J. Loughnan retired October 1 after 43 years of medical practice in Oconomowoc. The 87-year-old doctor and his wife will remain in Oconomowoc.

Doctor Loughnan

Doctor Loughnan's medical career began in the early 1900's when he was given his medical degree from the College of Physicians and Surgeons at the University of Maryland in Baltimore. Prior to entering the medical field, Doctor Loughnan graduated from Columbia University's Department of Pharmacy in 1893 following which he engaged in the drug business for a short time before entering medical school.

He practiced medicine in his home state of New York for two years before going to Chicago where he took a special course in eye, ear, nose and throat. Doctor Loughnan settled in Oconomowoc after a visit with Dr. Henry Voje who persuaded him to become an associate with him on the staff of Waldheim Sanatorium and Hospital (now Summit Hospital).

Doctor Loughnan remained with Doctor Voje for six years, then decided to begin his own medical practice in Oconomowoc. He is a past president of the Waukesha County Medical Society.

Doctor Faulds Observes Birthday

Dr. Robert C. Faulds, a familiar figure in the little community of Abrams, quietly observed his 90th birthday in October. Doctor Faulds has served the Abrams community for 60 years. He graduated in 1898 from the Wisconsin College of Physicians and Surgeons, Milwaukee. But as a young man his medical education had to wait until he saved enough money teaching school to realize his ambition. Doctor Faulds estimates that he has delivered about 3,000 babies during his first 50 years of practice.

Elected to Mississippi Valley Group

Dr. Wallace Marshall, Watertown, was elected a vice-president of the Mississippi Valley Medical Society at the annual business meeting of the Board of Directors held in Quincy, Illinois, on Sunday,

(continued)

November 22, at the Lincoln-Douglas Hotel. Three other Wisconsin physicians are on the 1960 Board of Directors. They are *Drs. Jack A. Klieger*, Milwaukee, *Leslie W. Tasche*, Sheboygan, and *Walter C. Roth*, Racine.

St. Francis Day at La Crosse

Coulee Region physicians numbering more than 50 heard talks and watched demonstrations November 4 when they were guests of the chiefs of staff at St. Francis Hospital in La Crosse.

In addition to presentation of papers by chiefs of staff of St. Francis Hospital departments, demonstrations were presented of the latest laboratory and therapeutic equipment available in the hospital.

Dr. Paul Dietz talked on clinical laboratory tests; *Dr. James Fox*, on current treatment of high blood pressure; and *Dr. Gregory Egan*, on agammaglobulinemia, a blood disease of children. *Dr. Archie Britt* commented on modern surgical methods in vascular disease and *Dr. George Ellenz* on specialized techniques in x-ray diagnosis of lung disorders.

This was the first of a series of "St. Francis Day" meetings, a planned annual affair at the hospital.

Participate in Interstate Assembly

The following physicians participated in the 44th International Medical Assembly of the Interstate Postgraduate Medical Association in Chicago November 2–5:

Dr. Francis M. Forster, professor and chairman, Department of Neurology, UW Medical School, Madison. His subject: "Drugs Most Effective in the Control of Epilepsy."

Dr. Miles B. Smith, associate professor of surgery, MU School of Medicine, Milwaukee, and chief, Surgical Service, Veterans Administration Center, Wood. He was a member of a panel on "Resistant Staphylococcus Infections."

Dr. Wilson Weisel, assistant clinical professor of surgery, MU School of Medicine, Milwaukee. He participated in a panel on "Treatment of Multiple Injuries Associated with Auto Accidents," and in particular his subject was "Crushing Chest Injuries."

Dr. William W. Engstrom, professor and chairman, Department of Medicine, MU School of Medicine, Milwaukee. His subject: "Thyroid Function in Pregnancy."

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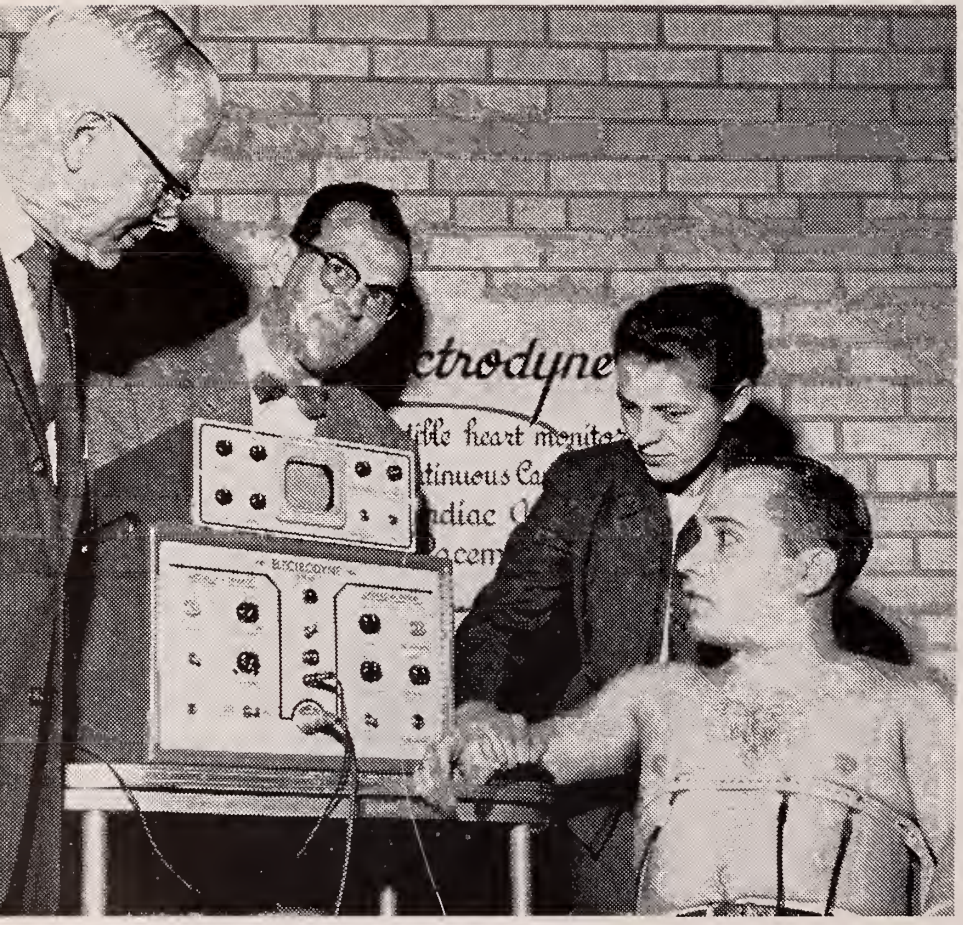

Presenting a demonstration at "St. Francis Day" in La Crosse are left to right: Dr. K. P. Ruppenthal, Bangor; Dr. E. O. Lukasek, Sparta; Dr. H. J. Virning, Caledonia; and William Ryder, R.N., Eau Claire, student anesthetist.

La Crosse Tribune Photo

Dr. Manucher J. Javid, professor of neurosurgery, UW Medical School, Madison. His subject: "A New Method for the Reduction of Intracranial Pressure with Urea."

Dr. Ovid O. Meyer, professor of medicine, UW Medical School, Madison, led a breakfast conference on "Newer Drugs and Their Uses."

Doctor Kohn and His Exhibit

Chicago Photographers Photo

Dr. Albert M. Kohn, left, Stevens Point, discusses his prize-winning scientific exhibit at the 45th annual meeting of Radiological Society of North America held November 16–20 in Chicago. Titled "Soft Tissue Alterations and Subtle Fractures at the Elbow," the display was awarded a Certificate of Merit by Society officials.

THIRD AND TWELFTH DISTRICT NEWS

Milwaukee Doctor Attends European Conferences

In October *Dr. A. W. Hankwitz* of Milwaukee was a participant on a panel of medical specialists at the 12th Annual International Air Safety Seminar held at the Riviera, Nice, France. He also attended the Fourth European World Congress of Aeronautical and Space Medicine in Rome, Italy. The Flight Safety Foundation, Inc. sponsored his trip.

Doctor Hankwitz, a former U. S. Air Force flight surgeon, is past president of the Wisconsin Civil Air Patrol and a member of the Air Service Committee of the Milwaukee Association of Commerce.

Cudahy Gets New Doctor

Dr. Z. P. Marcich, a general practitioner, has opened an office in Cudahy. A native of Yugoslavia, Doctor Marcich graduated from Zagreb in 1943, took postgraduate work in Italy, Switzerland and Yugoslavia, and practiced in Rome, Italy. He has been located in the Milwaukee area since 1956, spending two years in an internship-residency program at St. Luke's Hospital and the past year taking night calls at Trinity Memorial Hospital.

Besides his abilities in the medical profession, Doctor Marcich is also a linguist, being able to speak in several languages including Croatian-Serbian, Italian, German, French and English. He obtained his United States citizenship in September of this year.

Doctor Supernaw Speaks

Members of the Four Lakes Secretaries' Association met November 15 at a Madison restaurant to hear *Dr. J. S. Supernaw*, Madison surgeon, deliver a lecture. The topic "Gems and Stones" was chosen because of his active interest for many years in geology. This has in later years stimulated work by him in the field of lapidary.

Dr. Milton Davis, Jr., Becomes Medical Missionary

A Madison anesthesiologist, *Dr. Milton Davis, Jr.*, left in December with his family to teach at the Christian Medical College and Hospital at Ludhiana, Punjab, India. His wife will do secretarial duties in the hospital. Their work is sponsored by the Board of Missions of the Methodist Church.

Doctor Davis was graduated from the University of Louisville School of Medicine in 1940 and has taught at the University of Illinois Research Hospital, the University of Louisville Medical School and the University of Wisconsin Medical School. He was currently associated with Madison Physician Anesthetists.

Surgeon Begins Practice in Madison

Dr. Roy W. Zimmer, Jr., having recently completed postgraduate studies in general and thoracic surgery at the Mayo Clinic, Rochester, Minnesota, has opened an office in Madison.

Doctor Zimmer

After graduating from high school in Madison, Doctor Zimmer received both his B.S. and M.D. degrees from the University of Wisconsin, interned at Fitzsimmons Army Hospital, Denver, Colorado, and went into active duty in the Air Force in June of 1954. He attended the School of Aviation Medicine at San Antonio, Texas, and served as a flight surgeon in the military until release in 1955. At that time he went to Rochester to complete his medical training.

Woman's Club Hears Doctor Jackson

Dr. Arnold Jackson was guest speaker at the 1959 Fall meeting of the Poynette Woman's Club. The

(continued)

Madison physician, a member of the medical group that traveled around the world on a good will tour in 1958 (a trip of 35,000 miles in 55 days), talked and showed colored slides of many sites visited, including Wake Island, Honolulu, Japan, Hong Kong, Thailand, India, Greece, and Rome. The traveling group, interested in singing, sang in every country visited to promote friendly relations, Doctor Jackson said. Mrs. Jackson assisted her husband in the presentation.

Doctor Samp Delivers Three Lectures

In keeping with his reputation as one of the leading disciples in the public education about cancer, *Dr. Robert Samp*, the medical and scientific director of the Wisconsin division of the American Cancer Society and assistant professor of surgery in the tumor clinic at the University Hospitals in Madison, recently delivered three talks. He addressed the members of the Sheboygan Knights of Columbus and their wives on October 22 and on November 20 spoke at a meeting of the Madison Press Club.

Earlier in October he spoke at Waukesha's first cancer open house which was held at the Veterans

Waukesha Daily Freeman Photo

Doctor Samp is shown above with a patient

of Foreign Wars clubhouse. His talk, "Facts of Life and Cancer", explained the relationship of smoking to cancer. Also on the program were *Drs. E. G. Schulz* and *Robert Monk*, both of Waukesha, who were available to answer questions concerning the movies presented and the exhibits and displays shown.

Doctor Samp has lectured on the subjects of cancer prevention, cancer detection and exposing cancer quackery to more than 1,000 audiences in 250 cities in 35 states and was key speaker last year at the American Cancer Society's national kickoff dinner in Chicago.

Milwaukee Doctors Give Report

Drs. M. G. Peterman and *E. M. Thomas*, Milwaukee, presented a report on "The Relationship of the Effectiveness of the Ketogenic Diet to Seizure Type and E.E.G. Pattern in Epilepsy" at the annual meeting of the Central Electroencephalographers Association at Chicago, November 21.

Doctor Banyai Is Speaker

Dr. Andrew L. Banyai, Chicago, Illinois, was one of the speakers on the scientific program of the Silver Anniversary Homecoming meeting of the American College of Chest Physicians, held in Albuquerque, New Mexico, October 14–17. His subject was "Applied Physiology in the Management of Cough." Also, on October 16 Doctor Banyai took part in a one-hour television program presenting the subject, "Cancer of the Lung." This television program, sponsored jointly by the Upjohn Company and by the American College of Chest Physicians, was video-taped for later national broadcast. Doctor Banyai is clinical professor of medicine, emeritus, of Marquette University School of Medicine.

Doctor Peterman Gives Address

Dr. M. G. Peterman of Milwaukee addressed the annual meeting of the District Medical Society in Minot, North Dakota, on October 22.

Lectureship Fund Honors Dr. McGary

A lasting tribute—a *Dr. Lester McGary* lectureship fund to provide lecturers for medical staff meetings at Madison General Hospital—highlighted the testimonial dinner given Doctor McGary on October 27 in Madison. Doctor McGary retired November 1 after 33 years serving as chief pathologist at Madison General Hospital. *Dr. Eugene J. Nordby* announced the establishment of the fund. He also presented the doctor with an engraved electric wrist watch as a gift from the Madison General Hospital medical staff, who sponsored the event.

Participate in Blood Bank Meeting

Two Milwaukee physicians participated in the scientific program of the 12th annual meeting of the American Association of Blood Banks held November 4–7 in Chicago, Illinois. They are: *Dr. T. J. Greenwalt*, Medical Director, Milwaukee Blood Center, Inc., and *Dr. Ned G. Maxwell*, Associate Director. Raymond F. Ambelang, Business Manager, and Betty Johnson McCarthy, M.T. (ASCP) of the Milwaukee Center were also on the program. *Dr. E. B. Edelman*, Milwaukee, is the Wisconsin representative.

What's New at the Medical Schools

New Faculty at University of Wisconsin

A former intern at University Hospitals, Robert O. Burns, M.D., has accepted a position as Assistant Chairman of Student Health at the Medical Center. Doctor Burns, who received an M.D. degree at the Medical College of Virginia and has held residencies in Medicine at that medical college, the C. & O. Hospital, Clifton Forge, Virginia and Memorial Hospital, Charleston, West Virginia, was Director of Medical Education at Memorial Hospital. Prior to coming to the Medical Center he was in private practice in Charleston and Huntington, West Virginia.

A neurologist from Columbia University, Hartwell G. Thompson, M.D., has accepted a position as Assistant Professor of Neurology at the Medical Center. His appointment began October 1. Doctor Thompson will teach and do research in clinical neurology with an interest in basic sciences. He received a B.A. degree at Yale University and an M.D. degree at Cornell University. He interned in surgery at Bellevue Hospital, New York and has held residencies in Surgery at Hartford Hospital in Connecticut, in medicine at Bellevue and in neurology at the Neurological Institute at Columbia-Presbyterian Medical Center in New York City. He has been on the staff of Columbia University since 1957, first, as a Research Fellow in the Institute of Cancer Research, and then as Instructor and Associate in the Department of Neurology.

The Department of Physiology has added Miss Barbara R. Landau to its staff. Miss Landau, a Ph.D. in Physiology from the University of Wisconsin, will teach Anatomy and Physiology to nursing students from Methodist and Madison General Hospitals. Prior to her appointment here she was an Instructor in Physiology at St. Louis University Medical School.

There are two new appointments in the Department of Medicine (Physical Therapy). Nancy T. Watts has been appointed Assistant Professor and Mary Jane Hayes, Instructor. Miss Watts received a B.A. degree in Zoology at Grinnell College and a Certificate in Physical Therapy at Simmons College. Prior to her appointment here she was supervisor of Physical Therapy at the University of Illinois Medical School. Miss Hayes received her B.S. degree in Home Economics and a Certificate in Physical Therapy at the University of Wisconsin. She had been employed at St. Mary's Hospital in Racine. Both Miss Watts and Miss Hayes will teach and do research in this department.

Alan D. Wade, Chief Social Worker at the Wisconsin Diagnostic Center and Assistant Clinical Professor of Social Work in the Department of Psychiatry, has resigned his positions at the Medical Center to accept a position as Assistant Professor on the faculty of the University of Chicago. Francis R. Redding, currently a Social Worker at the Diagnostic Center and a Clinical Instructor in the Department of Psychiatry, will take over his duties at the Diagnostic Center.

Dr. Charles W. Cotterman has been named professor of medical genetics beginning Feb. 1, 1960, and Dr. Jerzy E. Rose has been appointed professor of neurophysiology beginning July 1, 1960. Doctor Rose succeeds Prof. Konrad Akert who has transferred to the department of anatomy.

Doctor Cotterman earned his B.A. and Ph.D. degrees from Ohio State University. He has served on the faculty of that university, the University of Michigan, University of California at Davis, and currently is professor of genetics and biometry in the Graduate Research Institute of Baylor University.

Doctor Rose, a native of Poland, became an American citizen in 1943. He received his M.D. degree from Jagiellon University, Cracow, Poland and served there as a physician. Doctor Rose also served the U. S. Medical Corps in the Pacific Theater from 1943–46.

In 1946 he served as assistant professor of physiology and psychiatry and was in charge of the neurology research laboratory of the department of psychiatry at Johns Hopkins University School of Medicine. In 1950 he was promoted to associate professor of physiology and psychiatry at Johns Hopkins, a post he currently holds.

Workshop for School Teachers Planned

Marquette University School of Medicine, through the Uhrig Conference on Child Development and Mental Health, discussed the setting up of a workshop for school teachers on December 1 at the Brooks Memorial Union. The workshop had as its purpose the indoctrination of public and secondary school teachers in methods and attitudes which they might use in improving the mental health of students.

Benjamin D. Balser, M.D., Associate Professor of Psychiatry at Columbia University, was a consultant to the planning group. Doctor Balser has had considerable experience in using such workshops as a guide for teachers and has reported on them as a model for improving mental health.

The Uhrig Conference on Child Development and Mental Health was begun in July, 1958, at which time a committee was formed to plan a series of lectures and visits by outstanding authorities in the field of child development and mental health. The conference was set up by the Uhrig Foundation, a foundation which aids Wisconsin children. At the time the conference was organized, J. C. Peterson, M.D., Professor and Chairman of the Department of Pediatrics at the medical school, and conference

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chairman, stated that "some of the most pressing needs of this community are the ones concerned with emotional problems of our children." He said, "An evaluation of these needs by authorities would contribute significantly toward the development of educational and service programs for the treatment and prevention of emotional disorders in children."

Besides the lecture which each authority was asked to give, he was also requested to remain as a consultant to a special conference group for a few days. The special conference group is comprised of local professional people who are intimately connected with the emotional needs of children—psychiatrists, pediatricians, school board members, health agencies, etc.

The conference group, since its inception, has recognized that there is a lack of availability of trained personnel in the Milwaukee area in child development and mental health. A program to train child psychiatrists and ancillary personnel is presently being planned by the medical school.

In planning the workshop for teachers the conference hopes to establish an on-going program through which responsible people in the community can improve their skills in dealing with some aspects of the mental health of children.

James King Appointed

Effective December 1, James F. King began as Director of Public Information at Marquette University School of Medicine succeeding Mrs. James J. Brophy who is leaving the city. Mr. King has been Director of Athletic Publicity since 1951 at the University. He is a 1950 graduate of Marquette's College of Journalism and is a member of Sigma Delta Chi, national journalism fraternity.

Mr. King's duties will include the following: 1. Preparation of copy for press releases and information on Pamphlets; 2. Assistance in establishment of public relations program; 3. Assistance in preparing information for fund raising; 4. Exploration of new channels for publicity for the medical school; 5. Maintenance of very close contact with the alumni association; 6. Promotion of the *Marquette Medical Review* and assisting the students in the publication of the Review; and 7. Supervision of special events.

Mr. King is the son of Joseph M. King, M.D., Clinical Professor of Surgery at the medical school, and Director of Surgery at the Milwaukee County Hospital.

Photographer Has Color Print on Cover of Journal

Anthony M. Kuzma, medical photographer in the Department of Pathology of Marquette University School of Medicine, will have a colored print of "Nonosteogenic fibroma: Fibula" on the cover of the next issue of *Medical Radiography and Photography* (Vol. 35, #2, 1959–60). The journal is published by Eastman Kodak of Rochester, New York.

UW Medical School Enrollment—1959–60

Medical students—341; nurses—352; residents—122; interns—17; occupational therapists—114; physical therapists—123; medical technologists—140; x-ray technicians—17; dietitians—5; graduate students in the basic sciences—79; making a total of 1,310.

Nutrition Study in Vietnam

Peter Moore, instructor in Pharmacology and Toxicology at the University of Wisconsin, left October 6 to participate in a Nutrition Survey in Vietnam, sponsored by the Interdepartmental Committee on Nutrition for National Defense. The purpose of the survey is an evaluation of the nutritional status, diets, and habits of the populations in newly developing areas with recommendations for improving dietary conditions when the need exists.

Panel Discussion Taped for Radio

While in Israel this summer Dr. Karver Puestow, Professor of Medicine, Menahem Monsoor, Chairman of the Hebrew Department of the University of Wisconsin, Reverend Walter Wagner, Calvary Lutheran Church, Madison and Stanley Christenson of Watertown participated in a panel discussion on conditions in Israel. Doctor Puestow spoke particularly on his observations pertaining to Medicine. This panel discussion has been taped for release by Radio Station W.H.A.

Doctor Peckham Honored

Dr. Ben M. Peckham, Professor and Chairman of the Department of Gynecology and Obstetrics at the University of Wisconsin, was honored as a distinguished alumni during ceremonies marking Northwestern Medical School's centennial. Doctor Peckham, who received the degrees of M.D. in 1942, M.S. in 1947 and Ph.D. in 1949, is one of 20 alumni to be so honored for outstanding work in academic medicine. The Centennial Merit Award presented to him cites his contributions to the study and treatment of carcinoma of the female reproductive organs.

Preceptors Met In October

Preceptors from the fifteen centers throughout the state attended an annual fall meeting, Friday, October 23, at the University of Wisconsin Medical Center. Educational problems and associated aspects of the preceptor program were discussed. That evening a dinner for the preceptors and medical center faculty was held at the State Medical Society Headquarters in Madison.

School of Nursing Receives Bequest

The School of Nursing of the University of Wisconsin Medical Center has received a bequest from the estate of Walter B. Schulte, late husband of Helen Denne Schulte, former Director of the School of Nursing, for the establishment of the "Helen Denne Schulte Loan Fund" to be used to further

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graduate and postgraduate education of qualified nurses. The bequest, which may approximate $100,000, is believed to be one of the largest ever received by a school of nursing for this purpose.

"Work and the Heart" Published

Work and the Heart, a monograph edited by Francis F. Rosenbaum, M.D., Associate Clinical Professor of Medicine at Marquette University School of Medicine, and Elston L. Belknap, M.D., Professor and Chairman of the Department of Occupational and Environmental Medicine, has just been published by Paul B. Hoeber, Inc., New York. The book is the result of the Transactions of the First Wisconsin Conference on Work and the Heart held in Milwaukee May 15–18, 1957. It was sponsored jointly by the Wisconsin Heart Association and Marquette University School of Medicine in cooperation with the American Heart Association, the National Heart Institute, and the Industrial Health Council of the American Medical Association. Ninety-three authorities—internists, cardiologists, pathologists, biophysicists, specialists in industrial medicine, and attorneys—representing the many fields needed to encompass the subject, participated in the conference and contributed to the text.

Doctor Belknap, Director of the Conference, said the conference was initially proposed to bring out the current thinking concerning the influence of work, exercise, and stress upon the heart, not only as it concerns athletes and persons occupied in strenuous physical work, but on a broader plane—as it affects people of all ages—both those with heart disease and those with normal hearts. The aim of the conference was to point out the deficiencies in the already existing information and the direction for future research and investigation.

Students Honored at University Convocation

Marquette University held its annual President's Convocation on October 22 at the Milwaukee Auditorium. Scholastic leaders from nine of the University's schools and its two military departments were honored. A luncheon for honor students, members of Alpha Sigma Nu and Gamma Pi Epsilon, national Jesuit honor societies, and for parents followed the convocation at the Schroeder Hotel. From the School of Medicine, the following students and alumni were cited for high scholastic averages during the '58–'59 school year: Senior: Dr. Richard Park; Junior: Alan E. Lewis; Sophomore: Guenther P. Pohlmann; Freshman: Salvatore A. Spicuzza; Student with the highest average over a period of four years: Dr. Michael J. Regan.

Dr. Hellmuth Speaks in Iowa

George A. Hellmuth, M.D., Associate Professor of Occupational and Environmental Medicine, MU, spoke on "Current philosophy and methodology in cardiac rehabilitation" at a meeting on Rehabilitation of the Cardiac in Business and Industry at the Iowa Heart Association in Cedar Rapids, Iowa, on November 4.

Dr. Pisciotta Gives Talks

Anthony V. Pisciotta, M.D., Associate Professor of Medicine, MU, spoke on "Reduced glutathione content of leukocytes in various hematologic states" at a meeting of the American Society of Hematology in St. Louis on November 24.

On December 2 Doctor Pisciotta gave a paper at the South Nassau Community Hospital, Oceanside, New York, on "The significance of abnormal leukocyte count in systemic disease."

Doctor Hirschboeck Accepts Check

Cordinal Studio Photo

Doctor John S. Hirschboeck, right, Dean of Marquette University School of Medicine, accepts a check for $5,000 from Dr. William H. Wilkinson, Wyeth Laboratories' medical staff. The presentation took place December 1 at the Aliota Restaurant in Milwaukee. The grant is one of 20 awards totaling $100,000 made annually by the Philadelphia pharmaceutical manufacturing firm to selected medical schools and hospitals. The recipients may use the funds for any purpose they desire.

Speaks at UW Postgraduate Session

Wisconsin physicians were told recently at a postgraduate course sponsored by the University of Wisconsin Medical School of a cancer diagnosis technique that can be done in about five minutes. Speaking at the fifth annual "Fall Cancer Scrimmage", Dr. Lauren Ackerman said this method consists of rapidly freezing cells suspected to be cancerous, staining, and studying them immediately under a microscope. The new method is called the frozen section technique, and can be done during surgery. The diagnosis can be made in five minutes instead of the usual hours or days. Doctor Ackerman, a professor at Washington University in St.

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Louis, said the technique requires at the most $1,000 worth of additional equipment. The program, designed to inform Wisconsin doctors of the latest research in the treatment of cancer, was sponsored by the American Cancer Society and the University.

Dr. Middleton on Military Surgeons Board

Dr. William S. Middleton, Medical Director of Veterans Administration, Washington, D. C., was elected fifth vice-president for the 1959–1960 term of the Association of Military Surgeons at its 66th annual convention held November 9–11 in Washington, D. C. Doctor Middleton is a former dean of the University of Wisconsin Medical School.

Dr. Eugene Turrell Speaks

Dr. Eugene Turrell, chairman of the department of psychiatry at Marquette University School of Medicine, Milwaukee, spoke at the annual meeting of the Lakeside Children's Center on November 3. He said that Milwaukee must start from the bottom to build up a teaching program in child psychiatry. He added that he has been "touring the country" for one child psychiatrist to start a child psychiatry division. Adult psychiatrists are scarce but child psychiatrists are even more scarce, he stated. Doctor Turrell said that one reason is that they are required to train for six years after medical school graduation, compared with the four-year postgraduate training for adult psychiatrists. "Child psychiatry is badly needed if we are to make any headway in preventive work," he said.

Attend Anesthesiologist Annual Meeting

Drs. Betty J. Bamforth, Karl L. Siebecker, and O. S. Orth, of the Department of Anesthesiology, University of Wisconsin Medical School, attended and presented papers or participated in the graduate refresher course program held in conjunction with the annual meeting of the American Society of Anesthesiologists at Bal Harbour, Florida, early in October. Doctor Orth was a member of the program committee. An educational exhibit, "Anesthesia-Wisconsin," prepared by Doctor Siebecker and Mr. James Kimmey, who also attended the meeting, received a "Special Merit Award." Emeritus Professor of Anesthesiology, Ralph M. Waters, and Mrs. Waters were the honored guests at the meeting.

Board Certified in Otolaryngology

Two members of the clinical staff of the Department of Surgery (Otolaryngology), UW Medical School, Drs. James Land and John J. Scott, in October were certified to the American Board of Otolaryngology.

Attend Clinical Research Meeting

Many investigators from the Departments of Medicine and Pediatrics, UW Medical School, attended the meetings of the Central Society for Clinical Research and the Midwest Section of the American Foundation for Clinical Research held in Chicago November 3–8. Dr. E. S. Gordon, professor of medicine, and Dr. D. G. Graham, associate professor of medicine, presented a paper entitled, "Metabolic Edema," at the meetings. Most of the individuals attending also presented scientific papers or otherwise participated in the meetings.

Brazilian Visitor at UW

Dr. Carlos F. Ferreira Da Costa, professor of medicine, University of Parana, Brazil, visited the University of Wisconsin Medical Center recently. Doctor Da Costa is a participant in the Foreign Leaders Program of the International Educational Exchange Service of the U. S. Department of State and was interested in observing the administration, teaching methods and research program of American medical schools.

Diplomate in Plastic Surgery

Dr. Gordon Davenport, clinical instructor in surgery, UW Medical School, has received notification that he is now a diplomate of the American Board of Plastic Surgery, following successful completion of examinations held recently in Miami, Florida.

Pediatric Research Forms Society

The newly formed Central Society for Pediatric Research held its first meeting in Iowa City, Iowa, October 26 and 27. Dr. Nathan J. Smith, president of the Society, and Drs. David Smith, Charles C. Lobeck, H. K. Tenney, W. T. Bruns, of the Pediatric Department, UW Medical School, attended the meetings, and William Yount, fourth year medical student, presented a paper entitled, "The Effect of Pyridoxal Phosphate Erythrocyte Glutamic—Oxalacetic Transaminase."

Doctor Barker Visits

Samuel B. Barker, Ph.D., Professor of Pharmacology, University of Alabama Medical Center, visited the Department of Physiology of Marquette November 23–25 under the sponsorship of the Committee on Growth and Cancer. Doctor Barker spoke to the medical students November 24 in the Medical School Auditorium. The subject of his talk was "What is the thyroid hormone doing?" Doctor Barker developed one of the first methods of determining the protein-bound iodine in plasma of patients as a clinical technique for the diagnosis of thyroid disease.

Doctor Ajl Speaks to Sophomores

Samuel Ajl, Ph.D., Program Director of Metabolic Biology of the National Science Foundation, Washington, D.C., spoke to sophomore medical students at Marquette University School of Medicine on November 12. Subject of his talk was "Bacterial metabolites and their importance in human infection."

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Doctor Shapiro Gives Talks

Dr. H. H. Shapiro, associate clinical professor of medicine, UW Medical School, spoke to various county medical societies on coronary artery disease during October. On October 1 he was in Richland Center where he also participated in a heart clinic on October 20, in Gillett and in Black River Falls on October 27.

Attend Ophthalmology Meeting

Drs. Frederick A. Davis, Frederick J. Davis, Matthew D. Davis, Edward F. Purcell, Donald Peterson and Fred G. Blum of the clinical staff of surgery (ophthalmology), UW Medical School, attended the American Academy of Ophthalmology in Chicago from October 12 to October 16. Dr. Frederick Davis presented an instructional course entitled, "Sutures Used in Cataract Surgery".

Returns from New York Trip

Dr. Frederick E. Shideman, chairman of pharmacology and toxicology, UW Medical School, returned November 2 from a trip to Syracuse, New York, where he presented a lecture at the State University entitled, "Myocardial Catecholamines—Their Role in the Positive Inotropic Responses."

Doctor Burns Attends Meeting

Dr. R. E. Burns, professor of orthopedic surgery, UW Medical School, attended the meeting of the Clinical Orthopaedic Society in Memphis, Tennessee on October 23 and 24.

Lectures at UW Medical School

An eminent investigator, Dr. Klaus Bayreuther, Institute for Cell Research and Genetics, Karolinska Institute, Stockholm, Sweden, spoke on "The Chromosomes in the Primary Neoplastic Growth" on November 30 in the S.M.I. Auditorium. In collaboration with Dr. Eva Klein, the speaker has shown that transplantable tumors show marked abnormalities in the chromosome number and form.

Col. Albert J. Glass, a colonel in the Medical Corps, United States Army, spoke November 30 at an M.E.N.D. meeting on "Psychological Problems in Disaster Situations." He is chief psychiatry and neurology consultant in the Office of the Surgeon General, Department of the Army, Washington, D.C.

A visiting professor, P. C. Bucy, of the Department of Neurosurgery at Northwestern University, spoke December 5 at the Neurophysiology Colloquium. His subject was "The Neural Mechanism Controlling Skeletal Muscular Activity."

German Professor Visits UW

One of the original investigators on the use of low phenylalanine diet on mentally retarded children, Dr. Horst Bickel, professor of pediatrics, University of Marburg, Germany, was a recent visitor to the Department of Pediatrics, UW Medical School. He was a guest of Dr. Harry A. Waisman, professor of pediatrics. Doctor Bickel is visiting associate professor of pediatrics at Yale University, and his work on mentally retarded children was recently written up in the *Saturday Evening Post*. While here he lectured on "Amino Acidurias."

Elected President of Genetics Society

Dr. James F. Crow, professor and chairman of medical genetics, UW Medical School, has been elected president of the Genetics Society of America. Dr. N. E. Morton, assistant professor of the same department, has been appointed a representative of the Board of Directors of the American Society of Human Genetics to the Program Committee for the second International Congress of Human Genetics to be held in Rome in 1961. Both were speakers at the recently held meeting of the National Academy of Sciences in Bloomington, Indiana.

Doctor Warren to Speak

Joel Warren, Ph.D., Director of Virus Research, Research Laboratory in Virology, Charles Pfizer & Co., Terre Haute, Indiana, was a guest on a panel program sponsored by the Marquette chapter of the Student American Medical Association on December 15 in the Medical School Auditorium. Doctor Warren discussed "Live poliovirus." Also included on the panel were a number of faculty people and several medical students.

Attends Interstate Medical Assembly

Dr. Erwin R. Schmidt, professor and chairman of surgery, UW Medical School, attended the meeting of the Interstate Postgraduate Medical Assembly held recently in Chicago. Doctor Schmidt is secretary of this organization and was the program chairman this year. He was the moderator for the discussion on "Hand Surgery." This meeting had an attendance of 1,400 physicians.

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Obituaries

Dr. Isaac J. Sarfatty, Milwaukee, died August 30, following a three-month illness. He was 57 years of age.

Doctor Sarfatty was born in 1902 in Yugoslavia, and came to the United States as a youth. He was an alumnus of the University of Wisconsin, received his medical degree from Marquette University in 1934, interned at Mt. Sinai Hospital, Milwaukee, and spent two years in military service before opening an office for general practice in Milwaukee. Very shortly after re-entering army service in 1940, he became a flight surgeon. In the United States he was stationed in Spokane, Wash., Reading, Pa., and Colorado Springs, Colo., where he planned and directed the base hospital. Overseas, he served in Europe, North Africa and the Middle East. Upon discharge in 1946, he took two years of residency in psychiatry at Veterans' Hospital, Downey, Illinois. He served as chief of psychiatry at the V. A. Mental Hygiene Clinic of Madison, Wisconsin, and later at the Milwaukee regional office. He was in private practice for a short period.

At the time of his death, Doctor Sarfatty was staff psychiatrist at the Milwaukee Sanitarium, assistant professor of clinical psychiatry at Marquette University, vice-president of the Milwaukee County Mental Health Association, and a member of the Civil Defense and Disaster Committee. He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, The Association for the Advancement of Psycho-Therapy, The Milwaukee Neuro-Psychiatric Society (where he was a past president) and a Fellow of the American Psychiatric Association. He also had been certified by the American Board of Psychiatry.

He is survived by his widow, Esther, two sisters and three brothers.

Dr. S. C. Sitter, 52, died September 12 at the Veterans Administration Hospital in Napa county, California, where he was head of the department of psychiatry and neurology.

A native of Oshkosh and a former Milwaukeean, Doctor Sitter received his medical education at Marquette University, graduating in 1931. He interned in Milwaukee and immediately entered the Army, from which he received a medical discharge in 1955. During World War II, Doctor Sitter was held captive by the Japanese for nearly three years, having been taken prisoner while on the staff of general hospital no. 2 at Bataan.

Survivors include his widow and three sons.

Dr. E. W. Cauldwell, a 43-year-old Beloit pathologist died October 3.

Doctor Cauldwell was born in 1916 at Lemont, Illinois. In 1941 he received a master's degree in anatomy from Northwestern University and was an instructor in anatomy there for five years. He was a 1943 graduate of Northwestern Medical School and interned at Cook County Hospital, Chicago. Following two years in the Army Medical Corps where he served as pathologist with the 18th medical general laboratory in the Pacific theater, he spent three years in residency training at Illinois Masonic Hospital and Research and Educational Hospital. Doctor Cauldwell was assistant professor of pathology at the University of Illinois College of Medicine until coming to Beloit in 1952. Doctor Cauldwell conducted an extensive research program while at Northwestern Medical School and at Illinois Research Hospital and was the author of 21 published papers. He also was an associate professor of Beloit College, being responsible for the development of a hospital-college laboratory technicians' training school.

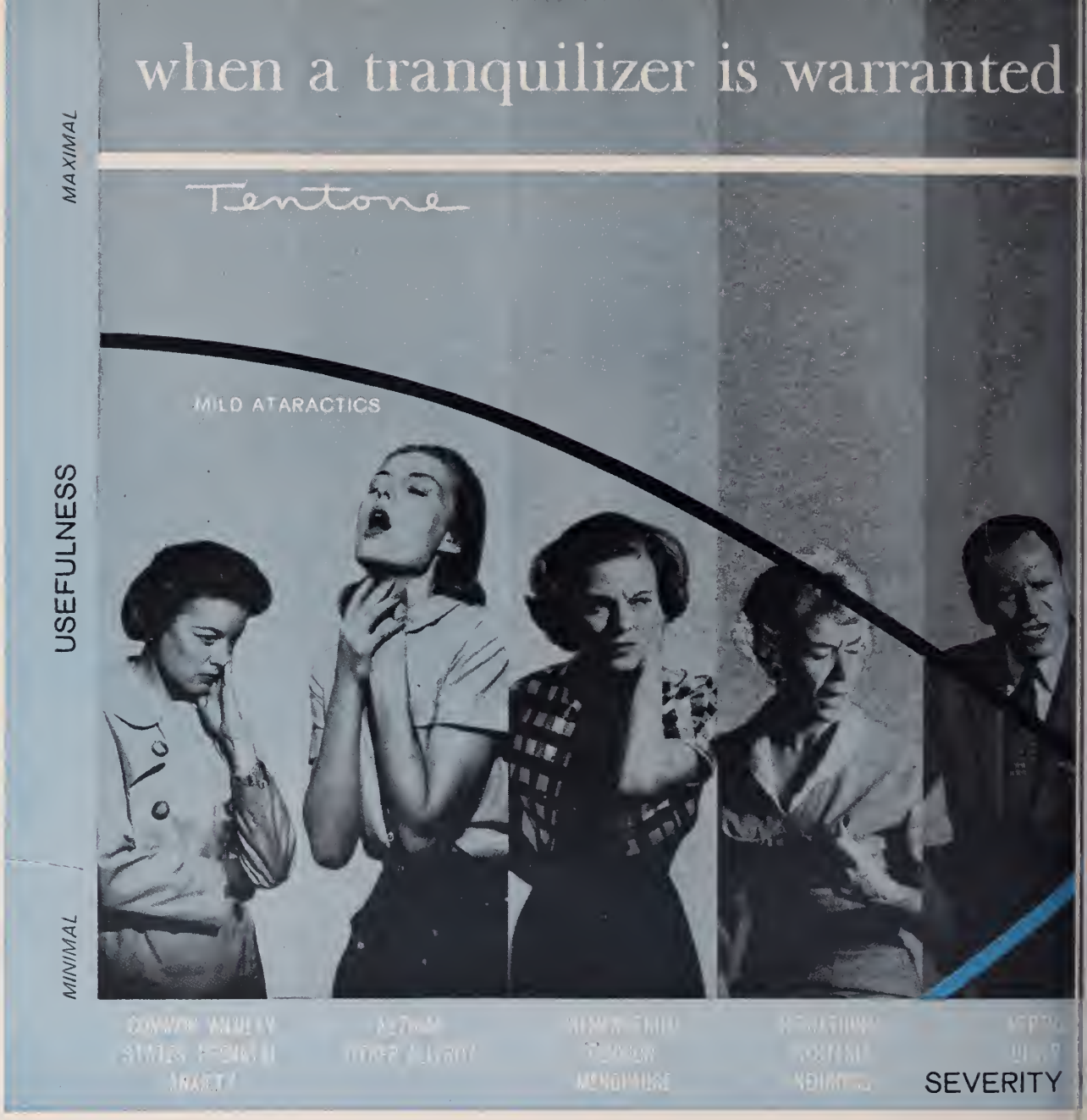
His medical affiliations included those with the Rock County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the American Association of Pathologists and Bacteriologists, the College of American Pathologists, the Wisconsin Society of Pathologists, the Minnesota Society of Clinical Pathologists, the American Association of Anatomists, the American Society of Clinical Pathologists, the New York Academy of Sciences, the American Association for the Advancement of Sciences, and was certified by the American Board of Pathology.

Surviving are his widow, Caroline; three sons, Malcolm, William and Alan, at home; and his parents, Dr. and Mrs. E. W. Cauldwell, Lemont, Illinois.

Dr. Frank Nee passed away October 9 at the age of 79. He had been a Spring Green physician for over 50 years.

Doctor Nee was born in Richland County in 1879, graduated from the University of Illinois School of Medicine in 1906, and immediately came to Spring Green to open his office for the general practice of medicine.

His widow, two sons and a daughter survive.



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P. H. Smith, 1005 Haywood Drive, Madison.
J. R. Spengler, 1300 University Avenue, Madison.
J. W. Hayden, 1836 South Avenue, La Crosse.
W. H. Walter, 925 Mound Street, Madison.
L. G. Walsh, 2018 Sherman Avenue, Madison.
A. P. Vastola, Jr., 1922 University Avenue, Madison.
J. T. King, 53 Merlham Drive, Madison.
Mary C. Berg, 543 State Street, Madison.
P. W. Clark, 212½ Main Street, Watertown.
T. J. Martens, Box 65, Athens.
W. R. Shaw, 808 North Third Street, Wausau.
T. M. Thorgersen, 808 Third Street, Wausau.
Harry Koenig, 3319 South Clay Street, Green Bay.
G. G. Giffen, 116 West Grand Avenue, Eau Claire.
R. E. Carlovsky, 86 Elm Acres Drive, Fond du Lac.
R. H. Graves, Box 682, Campbellsport.
Hans Hagel, 92 East Division Street, Fond du Lac.
S. D. Carlson, 1703 State Street, Eau Claire.
H. S. Waters, 512 St. Joseph Avenue, Marshfield.
V. W. Smith, Verona.
A. S. Evans, 1300 University Avenue, Madison.
G. J. Theiler, Jr., 205 East Walnut Street, Green Bay.
W. M. Stoll, Bellin Building, Green Bay.
D. H. Corser, 312 State Street, La Crosse.
J. A. Ottum, 400 Northern Building, Green Bay.
H. F. Sandmire, 430 South Webster Avenue, Green Bay.
J. M. Green, 1300 University Avenue, Madison.
J. R. Wong, 229 South Michigan Street, Prairie du Chien.

CHANGES OF ADDRESS

G. H. Stannard, Jr., Sheboygan, to Holy Family Hospital, Manitowoc.
H. E. Froede, Washington, D. C., to 8101 Eastern Avenue, Silver Spring, Maryland.
A. M. Kowalski, Lawton, Oklahoma, to 1424 Lancaster Place, Topeka, Kansas.
J. F. Orlovsky, *Fort Sheridan, Illinois, to 4944 South 92nd Street, Milwaukee.
J. W. Herbert, Beloit, to 2701 North Azalea, Victoria, Texas.
T. W. Klein, Janesville, to Route #1, Milton Junction.
R. W. Wilhoite, *Milwaukee, to % Mrs. Lucille Wilhoite, 511½ East Main Street, Waupun.
J. R. Nellen, *Milwaukee, to 6160th USAF Hospital, APO 929, San Francisco, California.
R. J. Fritz, Milwaukee, to 1300 University Avenue, Madison.
R. A. Berk, *Milwaukee, to 4509 Fir Street, Great Falls, Montana.
J. E. Groh, Milwaukee, to 4040 East Solano Drive, Phoenix, Arizona.
J. R. Bischel, Dousman, to 505 South Grand Avenue, Waukesha.
Janet J. Whitmore, Appleton, to 1115 Pacific Avenue, Everett, Washington.
D. U. Cookson, *Eglin Air Force Base, Florida, to 414 South Avenue, Fort Walton Beach, Florida.
R. J. Nickels, Wood, to 226 North 75th Street, Milwaukee.
W. A. Stoops, Baraboo, to 2804 Northwest 23rd Street, Oklahoma City 7, Oklahoma.
R. W. Schmitt, Phelps, to % Mr. R. L. Schmitt, 1308 Dayton Street, Madison.
R. L. Smith, Marshfield, to 110 Kilbounee, Sheridan, Wyoming.
J. P. Walker, Strum, to 109 West Main Street, Mondovi.
C. C. McGaughey, Madison, to R. R. #1, Beloit.
A. Y. Gerol, Monroe, to 126 Steeplechase Drive, Racine.
R. R. Mataczynski, A.P.O. 139, New York, New York, to 1514 Odgen Avenue, Superior.
B. W. Lyne, Neillsville, to 1111 First Street, Northwest, Rochester, Minnesota.
Beverly J. Olsen, Madison, to 240 Boice Street South, Salem, Oregon.
J. T. Petersik, Winnebago, to 421 Jefferson Street, Oshkosh.
W. M. Brown, Jr., Ann Arbor, Michigan, to 540 West Chambers Street, Milwaukee.
A. T. Holbrook, Milwaukee, to 535 Edgewater Drive, Dunedin, Florida.
I. R. Ohren, Milwaukee, to 12791 Regan Lane, Saratoga, California.
R. W. Wilhoite, *Waupun, to U.S. Naval Hospital, Navy 926 % FPO, San Francisco, California.
R. C. Zastrow, Bremerton, Washington, to 561 North 15th Street, Milwaukee.
D. E. Chisholm, *Menomonee Falls, to 6688 Via Reveria Way, Buena Park, California.
J. R. Caton, Racine, to 3432 North Hackett Avenue, Milwaukee.
J. J. Gordon, *San Lorenzo, California, to Naval Air Development Center, Johnsville, Pennsylvania.
M. T. Erickson, Highland, to 2429 Center Avenue, Madison.
C. L. Weisenthal, Wood, to 4918 North Idlewild Avenue, Milwaukee.
P. O. Simenstad, Osceola, to Veterans Administration Hospital, Minneapolis, Minnesota.
J. O. Simenstad, Osceola, to Ancker Hospital, St. Paul, Minnesota.
J. M. McGuire, Milwaukee, to 616 Mills Boulevard, El Paso, Texas.
J. R. Zell, Milwaukee, to 5051 North 34th Street, Phoenix, Arizona.

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Medical Meetings - Postgraduate Courses

Circuit Teaching Programs

A series of three circuit teaching programs will be held in January through arrangements made by the State Medical Society Council on Scientific Work in cooperation with the Wisconsin State Board of Health, Wisconsin Academy of General Practice, the two medical schools, Wisconsin Heart Association, Wisconsin Anti-tuberculosis Association, and Wisconsin Division of the American Cancer Society.

A special feature of these meetings will be an after-dinner illustrated lecture on "A Physician's Observations in Russia" by Dr. Francis M. Forster, chairman of the Department of Neurology, University of Wisconsin Medical School, who made a tour of Russia this past year and had the opportunity of visiting a number of medical schools and teachers. Wives of physicians in the areas of the meetings are urged to attend this nonscientific feature of the teaching program.

The first meeting will be held on January 19 at Viroqua in the Vernon County Memorial Hospital. Dr. George E. Collentine, Jr., Milwaukee, will be the moderator. Other physicians participating in the program include Drs. Donald M. Ruch, of Marquette University School of Medicine, Francis M. Forster and Charles R. Taborsky, of the University of Wisconsin Medical School.

The second meeting will be held January 20 at Waupun in the Waupun Memorial Hospital. On January 21 the meeting will be held at Appleton in the Elks Club.

Each of these programs provide 4 hours of Category I credit for members of the Wisconsin Academy of General Practice in attendance.

Reservations should be made in advance with the State Medical Society, Box 1109, Madison 1, Wisconsin, indicating whether for meeting, for dinner, and accompanied by wife. The fee for the meeting, including dinner, is $6.00, with an additional $4.00 if accompanied by wife.

North Shore Hospital Lecture

The fifth lecture in the Tenth North Shore Hospital Lecture Series on "Office Management of Emotional Disorders" will be held at the hospital, 225 Sheridan Road, in Winnetka, Illinois, on Wednesday, February 3, at 8 p.m. "Management of Psychoses in the Office" will be discussed by Dr. Benjamin Boshes, professor and chairman, Department of Neurology and Psychiatry, Northwestern University Medical School; chief of neurology and psychiatry, Chicago Wesley Memorial Hospital. The Commission on Education of the Illinois Academy of General Practice continues to approve these lectures for postgraduate credit. All physicians and allied professional personnel are cordially invited to attend these public service lectures.

Course on Laboratory Diagnosis

The University of Wisconsin Medical School will conduct a postgraduate course on "Laboratory Diagnosis for General Practitioners" on February 11–12. Dr. Frank C. Larson is the director. The course includes guest faculty. Tickets will be available to the Robert Shaw Chorale and Orchestra at the Wisconsin Union Theater on February 12.

The use of the laboratory in the establishment of diagnosis, in assisting with the differential diagnosis and in the control of therapy, will be considered. The course will stress practical applications usually available in the doctor's office or the community hospital laboratory. There will also be information concerning the availability and method of utilization of more complicated procedures usually available in larger medical centers.

Registration should be made with Dr. Robert C. Parkin, 418 North Randall Avenue, Madison 6, Wisconsin.

Postgraduate Course on Therapeutics

A postgraduate course on "Therapeutics" will be held at the University of Wisconsin Medical School on February 18 under the direction of Dr. Frederick E. Shideman. There will be consideration of four significant areas in which there have been recent developments in treatment. Each will be discussed by a lecturer and then submitted to a panel discussion and questions and answers. The problems of the physician in his office will be kept foremost in mind.

Registration should be made with Dr. Robert C. Parkin, 418 North Randall Avenue, Madison 6, Wisconsin.

Milwaukee Oto-Ophthalmic Society Meeting

On February 23 members of the Milwaukee Oto-Ophthalmic Society will hear Dr. Burton Waisbren speak on "The Use of Antibiotics in Diseases of the Eye, Ear, Nose and Throat." Doctor Waisbren is assistant clinical professor of medicine at Marquette University School of Medicine. The meeting will be held at the University Club in Milwaukee.

Minnesota Medical Courses

Medical continuation courses to be presented at the Center for Continuation Study, University of Minneosta, are as follows:

Jan. 11–13: Ophthalmology for Specialists
Jan. 21–23: Surgery for Surgeons
Feb. 8–10: Cardiovascular Diseases for General Physicians and Specialists
Feb. 15–19: Pediatric Neurology for Specialists
Feb. 29–Mar. 2: Pediatrics for General Physicians
Mar. 14–16: Internal Medicine for Internists

(continued)

Hawaiian Medical Meeting

Toru Nishigaya, M.D., President of the Hawaii Medical Association, has extended an invitation to all Wisconsin physicians to attend the 104th Annual Meeting of the Association to be held in Honolulu May 12–15, 1960. This will be the first meeting under statehood, which has given an added incentive to the Hawaiians to present an exceptionally fine program and social events.

Further information may be obtained by writing to Hawaii Medical Association, 510 South Beretania Street, Room 200, Honolulu 13, Hawaii.

International Course in Reconstructive Nasal Surgery

An international course on "The Fundamentals of Reconstructive Surgery of the External Nasal Pyramid and the Nasal Septum" will be presented in Mexico City, July 4–15. It will be under the auspices of the Escuela Nacional de Medicina e Division del Doctorado, and with the cooperation of the American Rhinologic Society.

The guest professor will be Dr. Maurice H. Cottle, professor of otolaryngology at the Chicago Medical School and founder of the American Rhinologic Society.

Applicants for the course must be diplomates of the American Board of Otolaryngology, or have equivalent status.

For application forms and other information, write immediately to Dr. Robert M. Hansen, secretary of the American Rhinologic Society, 1735 North Wheeler Avenue, Portland 12, Oregon.

Seminar in Reconstructive Nasal Surgery

A seminar in "Reconstructive Surgery of the Nasal Septum and External Nasal Pyramid" will be held in New Orleans, February 10–13, under the auspices of the Department of Otolaryngology (Dr. Val Fuchs, chairman), Louisiana State University Medical School, and the Charity Hospital.

The American Rhinologic Society will cooperate in the presentation.

For further information, write to Dr. Robert M. Hansen, secretary of the American Rhinologic Society, 1735 North Wheeler Avenue, Portland 12, Oregon.

Third International Congress of Physical Medicine

The Third International Congress of Physical Medicine will be held August 21–26, 1960 inclusive, at The Mayflower, Washington, D.C.

The preliminary prospectus covering the international conference carries in detail information on registration, application to present a paper, a scientific exhibit, a scientific film, etc. A copy of this preliminary program may be had on request by writing: Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2, Illinois.

WHO Dates to Remember

International Pharmaceutical Federation Congress, Copenhagen, Denmark, August 28–September 2, 1960.

XIVth General Assembly of The World Medical Association, West Berlin, Germany, September 16–22, 1960.

Forthcoming Meetings

First Congress, European Society of Ophthalmology, Athens, Greece, April 18–22, 1960.

Third International Congress on Medical Records, Edinburgh, Scotland, April 24–30, 1960.

Thirteenth World Health Assembly, Theme: Immunization in Communicable Disease Control, Geneva, Switzerland, May 3–27, 1960.

Twelfth Congress International College of Surgeons, Rome, Italy, May 15–18, 1960.

Fifty-first Annual Congress, Rotary International, Miami, Florida, May 29–June 2, 1960.

Annual National Tuberculosis Meeting

Plans are now being made for three days of scientific sessions at the Annual Meeting of the National Tuberculosis Association next May in Los Angeles, California. The scientific sessions will be sponsored by the NTA's medical section, the American Trudeau Society, and will be held May 16, 17, and 18, 1960.

In addition to sessions at which papers will be presented, there will be five panel discussions and seven luncheon seminars. The panels will be on the following topics: Childhood Tuberculosis; Tissue Culture Techniques and Mycobacterial Research; Steroids in Nontuberculous Pulmonary Diseases; Adenoviruses in Respiratory Diseases; and the Treatment of the Chemotherapy Failure. The seminars will be on the following subjects: Practical Pulmonary Function Testing; Treatment of Bone and Joint Tuberculosis; Compulsory Isolation of the Recalcitrant Patient; Air Pollution and Pulmonary Diseases; Indications for Lung Collapse Surgery of Lung Cancer; and Treatment of Empyema.

Philadelphia Meeting for GPs

The American Academy of General Practice will hold its 12th Annual Scientific Assembly, March 21–24, 1960, in Philadelphia's Convention Hall. More than 4,000 family doctors and 3,000 residents, interns, exhibitors and wives will attend the four-day program highlighting recent progress in medicine and surgery.

The Philadelphia Assembly program lists 31 prominent medical educators who will discuss a variety of subjects ranging from arthritis and anemia to surgery, geriatrics and mental health.

During the meeting, the doctors will have a chance to be on the other end of a stethoscope during physical examination sessions.

The scientific program will start at 1:30 p.m., Monday, March 21, and end at noon, Thursday, March 24. The Academy's policy-making Congress of

(continued)

Delegates will meet prior to the scientific sessions, at 2 p.m., Saturday, March 19. All sessions of the Congress and many social functions will be held in the Bellevue–Stratford hotel.

Wednesday evening, March 23, following induction ceremonies for Academy President-elect John Walsh, Sacramento, California, more than 2,000 guests will attend a reception and dance honoring President Fount Richardson, Fayetteville, Arkansas.

The Academy Assembly is this year combined with the Philadelphia Postgraduate Institute.

Puerto Rican Medical Meeting For Women

The Pan American Medical Women's Alliance is having its Seventh Congress in San Juan, Puerto Rico, June 3–8, 1960, at the Condado Hotel.

For those who are not familiar with the purposes of the Alliance, the following is quoted from the Constitution, Article II:

"The purpose of this Alliance is to bring the medical women of North, South, and Central America, and the Caribbean area into an association with each other for mutual improvement, encouragement for their participation in all branches of medical public welfare for the exchange of ideas and of improved treatment; to facilitate social and cooperative relations; to assist in the further education of its members through exchange fellowships and loans; and to generally forward such constructive movements as may be mutually beneficial and/or properly endorsed by the medical associations of our several countries."

An interesting program is being planned for this Congress with Dr. Cornelia Carithers of Jacksonville, Florida, as Program Chairman and Dra. Guadalupe Ayala Uribe of Mexico and Dra. Tegualda Ponce of Chile as co-chairmen.

At present, the registration fee has not been set but it is planned to have this fee cover registration fee for the Congress as well as the lunches and dinners. Breakfast and rooms will be on your own. Rates for the hotel rooms are not yet available. Plans should be made to arrive in San Juan on Friday, June 3. A welcoming dinner is being planned for Friday evening. Dra. Carmen Mejia, local arrangements chairman, is arranging a sight-seeing tour for Wednesday afternoon, June 8.

No plans have been made for a pre or post-convention tour. Each individual will make her own plans for visiting the Islands if she so wishes.

Applicants for membership to the Alliance should be made to Dr. Eva Cutright, 458 Beall Avenue, Wooster, Ohio, Treasurer. The fee is $4.00 for biennium 1959–1960.

New Orleans Medical Assembly

The twenty-third annual meeting of The New Orleans Graduate Medical Assembly will be held March 7, 8, 9, and 10, 1960, headquarters at The Roosevelt Hotel.

(continued)

WISCONSIN CALENDAR COMING EVENTS

1960

Jan. 12: Regular meeting, Dane County Medical Society, Nakoma Country Club, Madison.

Jan. 16: Regular meeting, SMS Council, Madison.

Jan. 19: Circuit teaching program, Vernon County Memorial Hospital, Viroqua.

Jan. 20: Circuit teaching program, Waupun Memorial Hospital, Waupun.

Jan. 21: Circuit teaching program, Elks Club, Appleton.

Jan. 21–22: Midwinter Safety Conference, Wisconsin State Board of Health, Milwaukee.

Jan. 26: Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

Feb. 11–12: Postgraduate course, Laboratory Diagnosis for General Practitioners, UW Medical Center, Madison.

Feb. 18: Postgraduate course in therapeutics, UW Medical Center, Madison.

Feb. 23: Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

Mar. 10–12: Postgraduate course in neurological problems, UW Medical Center, Madison.

Mar. 22: Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

Apr. 7–9: Postgraduate course in endocrinology in pediatrics, UW Medical Center, Madison.

Apr. 28: Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

May 3–5: SMS annual meeting, Milwaukee.

May 19–20: Postgraduate course in health aspects of air pollution, UW Medical Center, Madison.

May 26: Annual meeting, Milwaukee Oto-Ophthalmic Society, University Club, Milwaukee.

June 23: Teaching program on the heart and lung, for AAGP members, other interested physicans, Madison.

Note: Wisconsin specialty groups, medical schools, hospitals, and paramedical associations are invited to submit a list of their forthcoming meetings or courses for this calendar. Deadline for copy is first of month prior to month of publication. Address communications to: Wisconsin Medical Journal, Box 1109, Madison 1, Wisconsin.

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etate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

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LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-six informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical cruise on the M/S Franca "C" to the West Indies, leaving from Port Everglades, Florida, on Saturday, March 12. The itinerary includes visits to Puerto Rico, Virgin Islands, Martinique, Barbados, Trinidad, Curacao and Haiti, returning to Florida on Friday, March 25.

Details of the New Orleans meeting and the cruise are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

International Cytology Conference

Announcement that the International Conference of Cancer Cytology will be held in Mexico City in 1960, instead of in Madrid, Spain, was made in New York recently by Dr. J. Ernest Ayre and Dr. Locke Mackenzie, speaking on behalf of Dr. Sanz Ibanez of Spain who is President of the International Conference. The announcement followed a meeting of the Medical and Scientific Consultants of the Cancer Cytology Foundation of America, Inc. which is co-sponsoring the Conference with the Pan American Cancer Cytology Society, the National Cancer Institute of Spain, and other medical groups.

Dr. Ayre and Dr. Mackenzie, who are respectively President and U. S. National Chairman of the Pan American Cancer Cytology Society, stated the conference will meet jointly with the Pan American Medical Congress in Mexico City, May 2–11, 1960. The transfer will enable announcement of latest developments and discoveries in the science of cytology before the large gatherings of leading physicians, research scientists and dentists from the Western Hemisphere expected to number in excess of 7500. Dr. G. N. Papanicolaou, Pioneer in Cytology, is an Honorary Member of the Pan American Cancer Cytology Society.

The International Cancer Cytology Conference will bring together, by invitation, up to 300 leading authorities in the field of cancer cytology, as well as heads of WHO and UNESCO, to discuss ways and means of making cytology tests available to people of all countries. A major problem to be discussed at the International Conference will be the shortage of trained M. D. cytologists, cytopathologists, and cytology screeners. The Conference will discuss ways and means of developing training programs in countries where experienced teachers are available.

According to the Cancer Cytology Foundation of America, Inc., in the United States alone, the shortage of experienced cytologists, cytopathologists, and screeners is so acute that only a small percentage of the nation's adult women have the protection of an annual cervical cytology test, even though it is well known that through this study of the cells, indications of cervical cancer may be detected several years before the usual signs and symptoms appear. Newly developed techniques for the study of cells in the fluids of the throat and lung, prostate, and stomach are showing promise in cancer detection of these organs.

For information write to: Dr. Robert Nesbitt, Secretary, U. S. Office, International Conference, Union University, Albany, New York.

American Institute of Ultrasonics

The American Institute of Ultrasonics in Medicine will hold the Second International Conference on August 20, 1960 at the Statler–Hilton in Washington, D. C. The Chairman of the Program Committee is: Dorothy M. Stillwell, M. D., Chairman, Department of Physical Medicine & Rehabilitation, University of Colorado Medical Center, Denver 20, Colorado.

Those persons interested in presenting a paper at the scientific portion of the meeting should send an abstract of not more than 250 words to the Program Chairman for consideration.

Symposium on Venereal Diseases

The Eleventh Annual Symposium on Recent Advances in the Study of Venereal Diseases will be held April 7 and 8, 1960, in The Palmer House, Chicago. The sessions will be open to all physicians and workers in allied fields who are interested in the venereal diseases.

This Symposium, sponsored jointly by the American Venereal Disease Association and the Public Health Service, will follow a Venereal Disease Seminar for public health personnel which begins April 4.

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

Embryonic Nutrition. Edited by Dorothea Rudnick, Professor of Biology at Albertus Magnus College, New Haven, Connecticut. The University of Chicago Press, 5750 Ellis Avenue, Chicago 37, Illinois. 1958. 113 pages. Price: $3.25.

This volume on Embryonic Nutrition is one of ten volumes entitled, "Developmental Biology Conference Series of 1956." The various conferences were arranged for the summer of 1956 by Paul Weiss as general chairman and held under the auspices of the Division of Biology and Agriculture, National Academy of Sciences—National Research Council.

The participants for this Conference were drawn from the United States and abroad with some of the best scientific workers in this broad field. The choice of individual subjects is excellent and all the papers are well written with a lucid exposition of the data.

The first paper by Boell on energy exchange seemed more in tune with the intent of the Conference. It contained a thorough review and at the same time pointed out areas which should be examined more carefully. The second paper on, "Metabolic patterns in the Sea Urchin Embryo," is heavily burdened by data on this species with rare attempts at integration into the general field of development.

The subsequent papers on, "Yolk Utilization in Fishes", and "Nutrient Necessities in Chick Development", suffer somewhat for the same reason. Ebert's paper on, "Antigens as Tracers of Embryonic Synthesis," presents a very elegant method for study of embryonic differentiation. Moog's presentation on "Enzymes: Formation and Growth," revealed nothing new either in content or discussion.

In the preface to this series *perspective* and *relevance* were the key words and only comments which were of *strategic* or *catalytic* pertinence would be considered for inclusion in the discussion. This is a noble charge from the organizer but what was relevant in June of 1956 may not be in June of 1959; catalytic comments uttered 3 years ago can hardly be expected to retain their quality over the years. Thus, a volume which is otherwise excellent, becomes more of historical interest because of the delay in getting it into the hands of the reader. The individual authors have attempted to bring their manuscripts up to date. While this effort has made the manuscripts more timely it has outdated some of the comments offered in the discussion of each paper.

As a conference volume, this is excellent with the single deficiency of being a late-comer in a mushrooming field of interest to Biologists, Biochemists and Embryologists.—A. L. KENNAN, M. D.

Our Nuclear Adventure: its possibilities and perils. By D. G. Arnott. New York, Philosophical Library, Inc., 1958. Price $6.00.

This book by a British author describes for the lay reader the development of atomic energy and its use in peace and war. The need for atomic power plants in industry, particularly in countries lacking natural resources, is emphasized. The construction of a large number of such plants within the next decade will undoubtedly raise the living standards of a large proportion of the population of the world.

There is heavy emphasis on the potential dangers associated with the biological effects of ionizing radiations in case of accidents and in disposal of waste from the atomic reactors. A vivid but nevertheless somewhat cursory description of radiation effects on living cells fails to put the medical aspects of ionizing radiations into the right perspective. The beneficial effects of radiations on malignant tissues and the importance of the radioactive isotopes in diagnosis and research are completely ignored. Instead a highly emotional and somewhat querulous attitude is maintained regarding the potential hazards resulting from the use of ionizing radiations in medicine. Many statements have a definite political flavor and seem to be lacking the mature judgment which is so necessary for an objective evaluation of the impact of nuclear energy on society.

Nevertheless the interested student will find a good deal of accurate basic information regarding atomic energy and its effects. The book might therefore stimulate to further reading on this vitally important subject. Unfortunately very few references have been included.—HALVOR VERMUND, M. D.

Epilepsy. By Manfred Sakel, M.D. Philosophical Library, Inc., 15 East 40th Street, New York. 1958. 204 pages. Price: $5.00.

This is a posthumous work of the late Dr. Manfred Sakel, the discoverer of insulin therapy in the psychoses. The key of the book is in Poetzl's last paragraph of the Introduction, where he states "I have, therefore, attempted to set the analysis of the systems in the central nervous system into that parallel with a hormonal analysis of the vegetative nervous system, which had already been in Sakel's mind."

This is a rather strange book in many ways and covers in a rather superficial manner the traditional areas of epilepsy such as clinical diagnostic features —electroencephalography and medical therapy. The

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medical therapy is particularly weak covering some of the standard drugs but leaving out others such as Mysoline, Paradione, Milontin, and much of the book is given over to the study of vegetative systems in the matter of transplanting endocrine glands.

One has the feeling when reading this book that it has contributed little to neuroendocrinology of the understanding of epilepsy. It is always unpleasant to be critical of a book and this is especially so when it is posthumous, but this reviewer cannot in his conscience recommend this book to the physicians of the State of Wisconsin.—*Francis M. Forster, M.D.*

ANNOUNCEMENTS

Monograph Prizes

The American Academy of Arts and Sciences has announced its Monograph Prize Program which is an annual program now in its second year. There will be three awards of $1,000 each. The awards will be made to authors of unpublished monographs—one each in the fields of the humanities, social sciences, and physical and biological sciences. A Monograph is defined for the purposes of these awards as a "scholarly contribution to knowledge, too long for an article in a learned journal and too specialized for a general book." Recipients of these prizes will be expected to make their own arrangements for publication. The final date in 1960 for receipt of manuscripts by the committee on awards is October 1. Announcement of the awards will be made in December. Full details concerning these prizes may be secured on request by sending a stamped self-addressed envelope to the Committee on Monograph Prizes, American Academy of Arts and Sciences, 280 Newton Street, Brookline Station, Boston 46, Massachusetts.

Film on Post-Mortem Examination

The serious consequences of an inadequate post-mortem medical examination is brought to focus in "A MATTER OF FACT," the latest film in the Merrell medico-legal film series. The film was premiered August 24 and is now available for showing.

The public and doctors often do not understand the criminal and civil implications which may stem from an inadequate post-mortem examination: Innocent men may be falsely accused, insurance claims may not be honored properly and numerous other problems may result. In a suspenseful drama, "A MATTER OF FACT" highlights one of the more serious implications. The film portrays a typical situation in which an innocent man is accused of murder due to the lack of technical training of a county official.

"A MATTER OF FACT" is the fifth in a series of medico-legal films produced by The Wm. S. Merrell Company, Cincinnati pharmaceutical manufacturers, in cooperation with The American Medical Association and The American Bar Association.

"A MATTER OF FACT" is a 16 mm. black and white optical sound film, running time, 30 minutes. Prints are available for loan from The Wm. S. Merrell Company, Cincinnati 15, Ohio, and the American Medical Association.

Pamphlet on Estate Building for Crippled Children

A "first" in the literature on estate building has just been announced by the National Society for Crippled Children and Adults, the Easter Seal Society.

It is a long-sought publication that brings to parents sound advice on building an estate for a crippled child.

Written by George M. Rideout and John D. Riordan, long associated with the Babson Reports, the booklet covers important phases of will preparation, insurance planning, health and accident protection as safeguards to income maintenance, a yardstick for liquid savings, stocks versus bonds, real estate investment and home ownership, trust structures and guardianships.

The new publication is the fifth in a series of continuing pamphlets designed to help parents of crippled children. They are available through the National Society for Crippled Children and Adults, 2023 West Ogden Ave., Chicago 12, Ill., and its Easter Seal affiliates in all states, at 25 cents a copy.

American Board of Obstetrics and Gynecology

The Part I Examinations of the American Board of Obstetrics and Gynecology, are to be held in various parts of the United States and Canada, on Friday, January 16, 1960, at 2:00 P.M.

Candidates notified of their eligibility to participate in Part I must submit their case abstracts within thirty days of notification of eligibility. No candidate may take the Written Examination unless the case abstracts have been received in the office of the Secretary.

Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office: Robert L. Faulkner, M. D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

SMS Foundation —

A PILLAR OF FAITH IN MEDICINE YESTERDAY · TODAY · TOMORROW

Every physician should be vitally interested in the opportunities which the Foundation affords toward worthwhile giving in support of projects for the continuance of medical progress.

THE character of the medical profession shapes not only its own destiny but has profound influence on the health and well-being of all the people of Wisconsin. This character finds its root in the centuries-old American belief that individual freedom and well-being hinge on people helping themselves and one another. No where is this credo held in greater respect than among the members of the medical profession. For 117 years the State Medical Society of Wisconsin has reflected this spirit in its activities and services to the public and to member physicians. To do otherwise would violate the sacred vows of the Hippocratic oath as well as the public trust.

The Charitable, Educational and Scientific Foundation, created in 1955 by the State Medical Society of Wisconsin, is the newest born of a long line of vital instruments for public and professional service. The record of things accomplished in only four years spells substantial achievement. These, plus projects for the future, spell unlimited potential for the improvement of medicine and public health.

The Foundation is under the direction of a board of trustees composed of an elected member from each component county medical society and the councilors and officers of the State Medical Society. The latter constitute the executive committee of the board.

While this means that the Foundation is governed by a board of approximately 70 members, it seems basically important that there be a representative in each county society who will be informed of the affairs of the Foundation and who can handle inquiries, contributions, candidates for loans or grants, and other matters. With this continuing liaison at the county level and the Foundation under direct management of the governing body of the State Medical Society itself, the tradition and continuity of organized medicine in Wisconsin can be assured.

Financial support of the Foundation is achieved in many ways. Voluntary contributions are solicited of physicians each year in an amount determined by the House of Delegates. All physicians in active practice are solicited.

SPECIAL GIFTS ENCOURAGED

An increasing number of physicians make gifts to the Foundation in other ways. Some make an additional donation yearly at the time of solicitation of the voluntary contribution determined by the House. Others make special gifts annually, or whenever else they find it convenient. Still others do so by will.

Gifts can take a number of forms, all of which are welcome to the Foundation. One is cash; a second is life insurance; a third is securities; a fourth is land, with or without improvements; and still another is artifacts. The latter would typically include instruments, books or equipment typical of a particular period of medical practice. Also in this category would be correspondence, diaries, account books, class or community pictures, and the like.

In connection with the gift of a security to the Foundation from a living physician, a particular tax point should be emphasized. If that security cost a physician $1,000 some years ago, and it now has a market value of $4,000, the physician giving the security can take a deduction on his income tax return at the full market value of $4,000 rather than at his cost of $1,000.

If he were to sell the security, pay the capital gains tax to the federal government and the state income tax at his maximum rate, and make a gift of the balance, this would reduce the value of the gift, in an average situation, by about 35%. That would cause a substantial loss of principal to the Foundation and a corresponding tax disadvantage to the physician, both of which can be avoided by a direct gift of the security to the Foundation. Put another way, on the average, it will cost a physician about 50% more to make a gift of cash than a gift of securities on which there has been a substantial increase in value. The observations made with reference to a security are likewise applicable to land which has appreciated in value.

Where the gift is in the form of a life insurance policy, it should be made payable to the Foundation as the sole and irrevocable beneficiary, the physician also agreeing to continue the payment of the premiums. The cash surrender value, if any, at the time of such a gift, is deductible as a contribution on the physician's income tax returns. In a like manner, the premiums are deductible by the physician in the year in which they are paid. Further, the entire amount of the policy is exempt from federal estate taxes on the death of the person insured. While the Foundation may not benefit immediately from a gift of an insurance policy, it can undoubtedly find one or more uses for the proceeds when they are received. Meanwhile, it can borrow on the policy.

Another type of gift to the Foundation is a trust for its benefit, by the terms of which the income or principal, or both, are made available to the Foundation for a specified term of years, or permanently. The same results might be achieved by a restricted gift which is discussed in the next paragraph.

Gifts to the Foundation may be of two types. They may be unrestricted, in which event the Foundation is free to use them for any of the purposes for which it was established. The second is the restricted type, under which conditions of some sort are attached at the time the gift is made. An obvious example of the latter is a gift to the Student Loan Fund of the Foundation. Another would be a gift to the Medical Museum at Prairie du Chien. Still another might provide that only the income of the gift could be used for a specified purpose and a certain number of years, but that the principal could be used for unrestricted or restricted purposes after the time specified in the gift.

There are some disadvantages in restrictive gifts. One is the possibility that the object of the gift may disappear, or that it may receive ample funds from other sources at some subsequent date. A second is that a restricted gift imposes additional administrative burdens on the Foundation's staff. As a general proposition, it is liable that a board of trustees of some 70 physicians, plus its non-physician members, is in an excellent position to develop and to budget for projects worthy of the Foundation and consistent with its purposes.

It is not appropriate in an article of this type to suggest the phrasing which gifts should take. Where it is in cash or securities and unrestricted, a letter accompanying the gift will ordinarily suffice. Where the gift is restricted, or where real estate or a will is involved, it is essential that the physician consult his attorney on the legal phrasing, as well as the tax aspects of the gift.

Through advance consultation with the Foundation officers and staff, a physician and his attorney can assure themselves that the wishes of the donor will be fulfilled and that the gift itself will be used to the best possible advantage.

Non-medical persons, business and industry and other foundations have likewise found the Foundation an avenue of common interest and effort.

All contributions to the Foundation are deductible for income tax purposes.

The Foundation has developed a memorial card which is sent to the relatives or friends of deceased persons upon the request of the donor. Physicians and non-medical people can be assured that gifts may be ear-marked for special purposes, but at the same time it should be recognized that unspecified gifts will always be used for worthy, educational, charitable or research purposes in the medical field.

Every practicing physician recognizes the unquestionable need for timely aid to his needy kin of the profession. The public joins the physician in the realization that the amazing progress of man makes imperative the advancement of learning in scientific and learning fields if satisfactory solutions are to be found for a variety of medical and interrelated social problems.

Individual effort seldom has the opportunity to become significantly effective or to be given proper credit for a contribution to society. Now the Society's Charitable, Educational and Scientific Foundation offers physicians and the public an unprecedented opportunity to give of their substance to deserving causes of medical interest with the assurance that their contributions will be productively utilized and that posterity will be cognizant of their acts.

MEDICAL MUSEUM

One of the great educational and cultural institutions of the Midwest, if not of the nation, is in the making at Prairie du Chien. The establishment of the Medical Museum of Wisconsin on this site of historic Fort Crawford is the culmination of three decades of planning by the State Medical Society of Wisconsin.

The Foundation, by establishing the Medical Museum, will do far more than pay tribute to Dr. William Beaumont whose work at Fort Crawford laid the foundation of knowledge of gastric juice and digestion. It will build an institution with which medicine can launch an entirely new public educational program on the cause of specific disease, on early recognition, diagnosis and treatment; medicine's effort to prevent, control and cure disease; its basic concepts of disease and principles by which they are treated, controlled and prevented; and the nature of medical care and why the bond of confidence and trust between patient and physician is so essential to ethical and effective health care.

To carry out this new concept of a Medical Museum, it is proposed to construct and equip several buildings: a museum building itself; an administration building and curator's workshop; a curator's residence; a pavilion or social annex of the museum; and the restored military hospital of historic Fort Crawford in which Dr. William Beaumont lived and worked. Unlike the popular concept

Fort Crawford and museum as it will appear

of a museum, the Foundation's effort at Prairie du Chien will discard the "antique shop" approach and create a series of living, changing exhibits involving dioramas, motion pictures and periodically changing displays of an educational nature.

To accomplish this the Foundation has established a financial goal of $344,960. The initial fund program is already well under way with significant contributions from the physicians of Wisconsin. To the usual opportunities for contributions are added a number of memorial possibilities depending on the desires of the donor. When physicians have realized a substantial proportion of the fund goal, invitations will be extended to those outside the profession to participate in this medical-historical undertaking.

Prairie du Chien, rich in early Wisconsin history, has already become a showplace of the Midwest. In or near it are located several historic and archeologic attractions, such as the Villa Louis, the Brisbois house, Diamond Jo warehouse, the Astor fur-trading post, St. Gabriel's church, the French cemetery, the Fort Crawford cemetery, the Dousman cemetery, the pontoon railroad bridge over the Mississippi, Wyalusing State Park with its Indian mounds, and nearby Nelson Dewey State Park and Stonefield Museum. This past season more than 50,000 visitors paid admission to see the Villa Louis. According to estimates of the U. S. Division of Forests and Parks, by 1967 the number of annual visitors will have grown to 250,000 persons. One of the chief reasons for this influx is the proposed great Mississippi parkway which will follow the river from New Orleans to the twin cities of Minneapolis and St. Paul. The new highway will be adjacent to the property of the Medical Museum of Wisconsin.

The museum planning began in 1931 when the State Medical Society placed a granite memorial boulder on the site of the Fort Crawford hospital. During World War II, the House of Delegates of the Society endorsed the restoration of the Fort Crawford hospital and by 1954 interest in the development had expanded to the point where a Section on Medical History was established with a prime objective of the establishment of a medical museum on the site of the old hospital. In 1956 the entire property was deeded to the Foundation which recommended the founding of the museum. The Council of the Society voted its approval and in May of 1957, the House of Delegates gave unanimous approval to proceed with a campaign to complete the structure.

When the buildings are completed, their furnishings and operation will be undertaken in cooperation with the State Historical Society as a self-supporting venture.

The Medical Museum of Wisconsin will truly be an institution of public and professional education. In it the teaching by demonstration of the basic concepts of disease and the principles by which they are prevented, treated and controlled will portray the doctor in the proper framework with scientific progress, medical practice and social development. With it another Wisconsin first will soon be a reality —The Medical Museum of Wisconsin—the first of its kind in the nation.

STUDENT LOAN FUND

The financial needs of the modern medical student are so substantial that authorities estimate nearly 50% of the medical students at Marquette University School of Medicine in Milwaukee and the University of Wisconsin Medical School in Madison are at some point in their educational career so

financially embarrassed as to place their continued education in jeopardy. Both as an assistance to those who have already embarked upon a medical career and as an encouragement to those in the pre-college ages, the Society created the Student Loan Fund in 1951. With the establishment of the Foundation in 1955, the Student Loan Fund was absorbed by the Foundation and its operations continued and expanded.

Since 1951 a total of $63,104.95 has been loaned to 68 medical students. Eight students have since entered the practice of medicine and repaid their loans. Applications are constantly pending, their granting withheld for lack of funds.

As a matter of fact, those in direction of the Foundation estimate that the loan fund will not fully achieve its purpose until there is more than $250,000 available for needy and deserving students.

The Student Loan Fund is administered by the Executive Committee of the Foundation. Applicants must be registered students in an acceptable medical school. Because of current limitations on funds, all applicants must be residents of Wisconsin and attending either the University of Wisconsin Medical School or Marquette University School of Medicine. As soon as additional funds become available, these restrictions will be gradually withdrawn.

The student seeking a loan makes application through the Dean of the Medical School in which he is enrolled. After appropriate investigation, the Executive Committee approves the loan. Loans may be granted in an amount generally not to exceed $1,000 per year for a total of three years although exceptions may be made in special circumstances. No interest is assessed until the students are licensed after internship. All loans are secured by a life insurance policy in the amount of $2,000 or the amount of the loan, whichever is greater. A student who receives a loan from the Foundation places himself under no obligation to practice medicine in a predetermined location.

The recipients of loans come from 24 of Wisconsin's 71 counties: Brown, 2; Dane, 5; Douglas, 1; Eau Claire, 1; Fond du Lac, 3; Kenosha, 1; La Crosse, 1; Langlade, 1; Manitowoc, 1; Marathon, 2; Marinette, 2; Milwaukee, 14; Outagamie, 1; Pepin, 1; Racine, 4; Rock, 3; Sauk, 3; Shawano, 2; Sheboygan, 1; St. Croix, 1; Walworth, 1; Waukesha, 1; Wood, 1; Washburn, 1; and out-of-state, 6.

The Student Loan Fund of the Foundation has grown rapidly and served effectively. Through it physicians and others may make a singular contribution to those of their brothers for whom finances constitute a special hazard in the pursuit of professional knowledge.

CHARITY BEGINS AT HOME

The devotion of the physician to serving his patients is sometimes so steadfast that he may not see the opportunity to help those of his own colleagues to whom misfortune has come. The number of physicians and their families touched by severe disability, financial insecurity, or similar personal disaster is not great but it is nonetheless impressive. The files of the Foundation reveal true and touching cases in many areas of the state—30 or perhaps even 50 physicians or widows whose very existence hangs in the balance for want of financial aid, friendship or merely something useful to do.

The Foundation to date has made only a token contribution to those in more desperate need. What has been done is a story of quiet pride and great credit to a noble profession. What will happen in the future depends entirely upon the generosity of the profession in making contributions which can be used to assist colleagues or their widows in need.

INSTITUTE ON ATHLETIC INJURIES

That public health and scientific medicine can be served simultaneously was demonstrated in the Foundation's first Institute on Athletic Injuries held in Milwaukee on November 7, 1958. The Institute was presented as a scientific postgraduate education program for physicians which at the same time served to inform coaches and physical education directors on their responsibilities for the prevention, detection and first aid treatment of athletic injuries. The program was sponsored by the Foundation in cooperation with the Wisconsin Interscholastic Athletic Association, Wisconsin State High School Coaches Association, Wisconsin Academy of General Practice, Wisconsin State Board of Health, Wisconsin Heart Association, State Department of Public Instruction and the Wisconsin Orthopedic Society.

The program was attended by more than 700 coaches, physical education instructors and school administrators plus nearly 50 physicians.

INHALATION THERAPY INSTITUTES

The first postgraduate education project of the Foundation, made possible by a grant from the Red Arrow Sales Corporation of Madison, as sales agency of Linde Company, Chicago, was a series of two inhalation therapy institutes. The first was held in Milwaukee on October 30, 1957 and the second in Madison on November 15, 1957. The institutes attracted a total attendance of 155, including 112 practicing physicians and 13 residents, interns and medical students. The programs appealed to a substantial number of specialists and others who acquired the latest information in reference to the use of oxygen in their practices and in the hospitals of their communities. Again, these institutes provide a dramatic demonstration of how the Foundation can provide special teaching experiences in important areas of medical practice.

HEARING LOSS STUDIES

In the area of scientific research the Foundation has undertaken a hearing loss project made possible through a grant of $1,000 by the Nelson Muffler Corporation of Stoughton, Wisconsin. Under supervision of the Committee on Scientific Research of the Foundation, Maxine Bennett, M.D., University of Wisconsin Medical School, has been engaged to direct the study. She will be assisted by a resident and others of the medical school. Meyer S. Fox, M.D., Milwaukee, will serve as advisor. The problem is to determine if there is any associated or accompanying hearing loss in systemic disease (diabetes, coronary heart disease, etc.) which is not present in the healthy individual of the same age and sex. Actual study of clinical subjects has begun and may take as long as two years to complete. Medical authorities report no similar study has been made or reported in the scientific literature.

Audiometric testing being given at the University of Wisconsin Medical School as part of the industrial hearing loss study financed by the Foundation.

HEALTH INSURANCE FOR THE AGED

Significant social economic studies relating to the provision of more adequate health insurance for the aged have been undertaken in Wisconsin with the support of the Foundation. These research studies have been in operation since 1947 as a result of a commitment by Wisconsin Physicians Service, the Blue Shield plan of the State Medical Society, to the Foundation. These funds are being channeled through the School of Commerce of the University of Wisconsin by way of a special grant. The study is expected to assess the medical–economic needs of the aged in Wisconsin, and point the way to specific types of health insurance programs which can serve these people in some fashion that is socially and economically sound. Other funds are sought to enlarge the grants so that the initial studies may be carried into their final phases.

MEDICAL CARE IN THE HOSPITAL

Preliminary plans are underway through the Foundation to utilize a $10,000 grant made in 1957 by the Council of the State Medical Society of Wisconsin. The purpose of the grant was to initiate a study on what physicians in Wisconsin might do to reduce or stabilize the costs of medical care in cases of hospitalization. The purpose of the study will be limited to those areas of patient care in which the physician is or may be influential in the control of costs during hospitalization.

RESPIRATORY PROBLEMS IN CHILDREN WITH CLEFT PALATE AND HAIR LIP

A Foundation Committee has recommended a joint research effort by the Department of Surgery and the Department of Anesthesiology at the University of Wisconsin Medical School to determine the type of alteration occurring with operation of children with these congenital defects. It is also desired to determine the most feasible inhalation therapeutic measures to be used for maximum safety. The Committee is seeking financial support for the purchase of materials and apparatus which will make it possible to undertake the research program.

MEDICAL HISTORY

In cooperation with the Section on Medical History of the State Medical Society, the Foundation is interested in the judicious placement of historical markers along the highways of Wisconsin to remind the traveler that medical men and medical science are a part of their background. A travel map identifying these historical markers is proposed for early development. All members of the Society are being asked to recommend persons, buildings, locations and places which have medical historical interest in the state.

At the same time, the Foundation realizes its obligation to record through film, tape recordings and photographs the medical personalities, events and institutions as their role in society unfolds at the present time. Funds and equipment for this purpose are being sought by the Foundation as a means of recording current history.

Memorial Contributions

The Foundation has received contributions in the memory of the following individuals:

Mrs. L. O. Simenstad
Mrs. Ray Hoops
Mervin Hess
Rachel Macomber
W. J. Voellings, M.D.
Charles F. Fidler, M.D.
Walter B. Cannon, M.D.
S. C. Allen, M.D.
Mrs. Frances Burke
Mrs. W. H. Folsom
J. A. Schindler, M.D.
Mrs. Arbor Marsh
J. S. Hess, Sr., M.D.
Dr. George and Jenny Pomainville
Dr. E. L. Jewell
Dr. John Dodd and Dr. Edwin Ellis

Other Contributions

Contributions received by the Foundation from medical organizations and non-medical individuals or organizations include:

State Medical Society of Wisconsin
Wisconsin Physicians Service
Seefurth & McGiveran Consulting Services
Wisconsin State Dental Society
Nelson Muffler Corporation
Frank G. Brotz Family Foundation, Inc.
Red Arrow Sales Corporation—Linde Corp.
Helen Supernaw
F. A. Otto
Adolf Gundersen Medical Foundation
Beloit Medical Assistants
Robert B. Murphy
Donald E. Gill
C. H. Crownhart
Democrat Printing Company
Woman's Auxiliary of the State Medical Society of Wisconsin
Stuessy Clinic
Interstate Postgraduate Medical Corp. Publishing Co.
Wisconsin Academy of General Practice
American Academy of General Practice
Fred Pabst Foundation
Rennebohm Drug Store
Donald E. Gill & Company
Alfred D. Sumberg
Signe S. Cooper
Jackson Clinic
Margaret McDonald Smith
Kenosha County Medical Society
Minnesota State Medical Association
Carl Colby
Chippewa County Medical Society
Mrs. Valentine C. Kremser
Douglas County Medical Society
Wisconsin Society of Anesthesiologists
Elizabeth Stevens Jackson (Estate)

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

1. He is recommended for a temporary license by any physician licensed in Wisconsin.
2. He is under medical care.
3. While under medication he is free from seizures.
4. His driving is not otherwise a hazard to public safety.
5. His physician recertifies each six months that he is free from seizures.

The physician makes his certification on a combined questionnaire and recommendation form provided by the Motor Vehicle Department. The physician making such a recommendation must be the physician who is rendering treatment to the epileptic patient. The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board of five members. Four of these members are designated by the president of the State Board of Health.**

Reference: *Section 343.09, Wisconsin Statutes, 1957.*

** The fifth member is the Commissioner of the Motor Vehicle Department, and he and any two of the other members constitute a quorum.

CAN YOU PRACTICE WITHOUT A LICENSE?

Suppose you are just out of military service. Or you have just arrived in Wisconsin from another state. Dare you practice, either on a temporary or permanent basis, before you get your license?

Suppose you enter practice in association with one or more other physicians. May you practice before your licensing is complete?

Be careful! Your good intentions may be illegal practice. You may be subject to sharp criticism, or worse.

The best advice: Postpone any contact with patients until your Wisconsin licensure is complete.

The next best advice: Be circumspect. Issue no prescriptions over your own signature. See patients only in consultation with your associates who are already licensed. Act only as an apprentice or as a physician's deputy, never as a privately practicing physician.

Reference: Section 147.15, Wisconsin Statutes, as affected by Chapter 581, Session Laws, 1955.

Some of Your Income Can be Taxed At Only 20 Per Cent

Ten examples show you how the short term trust works

THE tax laws do contain some provisions which allow high income taxpayers to escape or reduce income taxes. The short term trust is one of these. Its use allows a high bracket taxpayer to rid himself of his most heavily taxed income in his highest income earning years. By creating a trust for 10 or more years the income non-taxed at the physician's top rate is taxed instead to a lower bracket trust or beneficiary. Then, in later years when your income is lower, you get your property back and the right to the income from it.

Here is a partial list of what you can accomplish for your family by setting up a short term trust:

(1) build a retirement fund
(2) build an educational fund for children
(3) support dependent relatives
(4) set up a son's business or provide daughter's dowry
(5) purchase life insurance for children
(6) build funds to insure liquidity of your estate upon your death
(7) transfer assets to grandchildren
(8) purchase real estate
(9) shift capital gains
(10) fund purchase of partner's business for benefit of son.

What you do is simply turn over income producing property to a trust which you create by a written agreement between you and a trustee. The trust must last for 10 or more years. The agreement can permit the trustee to accumulate the income during the 10 year or longer period and then distribute it to beneficiaries named in the agreement, or it can be distributed to them currently each year. It will be taxed to the trust if the income is accumulated or to the beneficiary if distributed currently. At the end of the period of the trust, the property comes back to you and you again become entitled to the income.

Setting up a trust is a gift for gift tax purposes. But if the trust is to last 10 years the value of the 10 year gift is only about 30% of the value of the property. Furthermore, most taxpayers haven't used up their lifetime federal gift tax exemption of $30,000. So the gift tax should not be too much of a problem to most taxpayers.

You'll need a lawyer to set up your trust and quite probably you'll want to discuss it with your accountant and investment broker as well as a bank trust officer.

Illustrations of Income Tax Savings Possible

Taxable Income of Creator of Trust:	*Tax Savings if Trust is Taxed and Property Produces Annually:*				*Tax Savings if Beneficiary* is Taxed and Property Produces Annually:*			
	$1000	*$2000*	*$3000*	*$5000*	*$1000*	*$2000*	*$3000*	*$5000*
$10,000	$ 80	$140	$ 142	$ 106	$198	$278	$ 313	$ 362
14,000	120	220	262	306	238	358	433	562
18,000	160	300	382	506	278	438	553	762
20,000	160	300	422	586	278	438	593	842
24,000	200	380	542	786	318	518	713	1042
28,000	250	480	692	1026	368	618	863	1282
32,000	290	560	812	1236	408	698	982	1492
50,000	410	800	1172	1876	528	938	1343	2132

* Assumes Beneficiary has no other income.

Examples of How the Short Term Trust Works:

1. Retirement Fund or Deferred Compensation Plan

You *can't* set up a short term trust for *your own* benefit. But there is nothing to prevent you from setting one up for your wife. You don't want the income paid out currently to your wife because that would cause it to be taxed at the same high rates applicable when you and your wife file joint returns. So you give the trustee the discretion to accumulate the income for her. It is then taxed to the trust at the 20% or 22% rates. At the end of the term of the trust the income is paid to your wife and she then helps support you and your family out of this fund.

If you are a 50% bracket taxpayer and you put $50,000 of securities paying an average of 4% annual return, you can annually build up a retirement fund from income tax savings alone of about $600.00. Assuming the trustee reinvests this saving during a 15 year period a fund of approximately $12,000 will have been built up just out of the tax savings. And you get back your $50,000, plus any principal growth, at the end of the 15 years.

Put another way, the trust can build up a fund, *after taxes*, of about $30,000 during the 15 year period. To have built a similar $30,000 fund with your 50% post tax dollars you would have needed to invest a fund of $85,000 instead of the $50,000. At the end of the 15 years, your wife can take the $30,000 and invest it, spend it, or buy an annuity.

2. Education Fund for Children

Many parents set aside funds annually for their children's college education. If you are a 50% taxpayer it takes $2,000 of income to set aside $1,000 for your children's education. Instead, if your children are young enough so that the 10-year minimum period of a trust ends before their education is completed, you can put income producing assets into a trust which accumulates the income and distributes it to your children at the end of the 10 years. They can then use it for their education. Doing it this way requires about $1,200 annual earnings to set aside the same $1,000.

You must be careful not to have the income used for the support or education of your children while it is still in trust. If this is done, the income will nonetheless be taxed to you. In our illustration, the income is *not* used until the trust is ended, so there is no problem.

During the period of the trust, the income could be reinvested in other securities or in endowment or life insurance policies payable or cashable at the end of 10 years.

You can even cut down the 20% tax payable on income earned by a trust for the benefit of your children if the trust can pay out to the children up to $599 annually. This amount could be put into a savings account for each child. The $599 paid out annually would escape tax entirely because it is less than the $600 exemption of your child.

3. Dependent Relative's Support

A short term trust can save you money if you are supporting a relative whom you have no legal obligation to support. A mother-in-law, or brother or sister are examples.

Assume you give your mother-in-law $200 a month to live on and that you are in the 50% bracket. This requires $400 of pre-tax monthly income. If your mother-in-law has no taxable income of her own, you can set up a trust paying her $200 per month for 10 years, or her lifetime, whichever is the lesser, and save yourself about $2,400 a year in income tax.

You would lose the exemption of $600 for your mother-in-law, but this would merely reduce your $2,400 tax saving by $300.

4. Increasing your Estate's Liquidity

Income from a trust you set up can't be used to pay premiums on policies insuring *your life*. But there is nothing to prevent your wife from using *her funds* to create a trust to pay premiums on life insurance on your life. The beneficiary of this trust created by your wife could be your children. You could empower the trustee, in the event of your death, to use the life insurance proceeds collected by it to purchase non-liquid assets from your estate. Thus you would have the life insurance cash available to your estate. Through this perfectly legal device you can get almost double the amount of insurance purchased for the same amount of pre-tax dollars.

5. Purchase of Life Insurance for Children

If you wish to get your son or daughter started in a life insurance program so as to get the benefit of low premium rates, consider payment of these premiums through a short term trust.

The trust can do it cheaper than you can because it is being done with low taxed dollars.

If you wanted to transfer a $25,000 paid-up policy to your 11-year-old son when he reached the age of 21, you could transfer $35,000 of 4% securities to a trust and the post tax income would be enough to finance a 10 pay life policy. If you are a 50% taxpayer it would have taken $70,000 of securities to produce enough after tax dollars to do the same thing.

Fewer funds, of course, need be put into the trust if you wish to finance lower premium policies during your child's minority such as an ordinary life policy.

6. Using Borrowed Funds to Set Up a Trust

Tax-wise it would be advantageous to you to borrow money and place the loan proceeds in a short term trust.

Assume that you could borrow $100,000 at 5% for 10 years and that you were in a 50% tax bracket. Because you now have an interest deduction, you have actually cut your income tax by $2,500 annually, so the $5,000 interest you pay will only cost you $2,500. The trust will have annual income of $5,000 if it also earns 5%, on which it will pay a tax of $1,074, but $3,926 of income, plus the income on reinvestment, can be accumulated annually for designated beneficiaries. At the end of the 10 years you get the $100,000 back plus any principal growth and you can repay the loan. Subtracting the interest cost to you of $2,500, the $3,926 nets out at an annual gain of $1,426.

This arrangement could be varied for purposes of buying or building a medical arts building or other rental property. You could borrow money to buy or erect the building and then transfer the building to a trust. If it is a medical arts building, you could lease it back from the trust. You must continue to pay the principal and interest installments on the mortgage rather than the trust; otherwise you will be taxed to the extent trust income is so used.

7. Grandfather Trusts

If you are a grandfather and want to protect your son's wife and children against the untimely death of your son in the years when he is getting started, you can do it advantageously with short term trusts for the benefit of your grandchildren and daughter-in-law set up to finance life insurance on your son's life. At the end of the 10 or 15 years, your son ought to be in a position to continue the premiums himself.

8. Shifting Capital Gains

If for example, you have property presently worth $10,000 that is expected to multiply in value in a few years, you can divert the capital gains tax from yourself to a trust or its beneficiary, with a substantial resultant saving.

9. Setting up a Son's Business, or Helping Out Newlyweds

Today many adult sons and daughters need help in the early years of their marriage or business careers. You can provide through short term trusts the same help with much less dollar outlay.

Suppose your daughter is 21 years of age and about to be married to a medical student and that you are in the 50% bracket. Suppose further you want to give her $1,000 a year. You can transfer securities or income property to a trust which pays all the income to her.

If you give her this out of your own pocket it is costing you $2,000 a year of income because you first must pay Uncle Sam $1,000 of tax.

If, on the other hand, you set up a trust for her benefit and transfer into it securities producing $1,000 of income, your daughter will still be receiving the $1,000. You, however, will actually be increasing your spendable income by $500! This is so because you have cut your income by $1,000 thus saving half of this in income tax. True, your income is also down by $1,000 but this is offset by your not having to give your daughter $1,000 any longer.

Typically your daughter will have little or no tax to pay, so this will be no deterrent.

10. Purchase of Partner's Business for Benefit of Son

If you have a son interested in coming into a partnership with you, and your partner had no son interested in doing likewise, purchase of life insurance on your partner's life can be advantageous to all concerned.

If a partnership buy and sell agreement were set up to allow your son to buy out your partner's interest at his death, the insurance on the partner's life necessary to fund the purchase could be financed by means of a short term trust set up by you, taxed at 20%.

* * *

These trusts are recognized under Wisconsin income tax laws as well. While the foregoing examples are only of federal tax savings, considering Wisconsin will only increase the total tax savings.

* * *

Remember that short term trusts lasting for 10 or more years are primarily income tax savers. If you should die during the term of the trust, some death taxes would be saved depending on whether death occurred early or late in the term.

Remember, too, that the creation of a trust is a gift of the right to receive the income for the term of the trust. Its creation may or may not result in a gift tax being payable.

Remember that setting up these trusts requires expert tax advice from a lawyer and accountant.

Kintner Type Association

It was reported in the January 1958 issue of THE WISCONSIN MEDICAL JOURNAL that the Internal Revenue Service planned to issue a ruling setting forth basic criteria under which it would recognize for tax purposes the "Kintner type" professional association and its companion retirement plan. Under such a retirement plan you could set aside a certain part of your top bracket income in your high income years and pay no tax until your retirement years when you are in much lower tax brackets.

Recently, the Internal Revenue Service has stated it would not publish such a ruling. It announced, however, that it would not discourage partnerships from going ahead with associations, taxed as corporations, having retirement plans in connection therewith. The announcement is applicable to medical partnerships.

To receive the tax benefits of a retirement plan, physicians must organize associations which are taxed as corporations, even though they are partnerships for other purposes. The Internal Revenue Service has indicated that it will apply to medical associations the same tests it applies to any other organization in deciding whether the organization is for tax purposes a corporation or partnership. Included in these tests are (1) centralization of management in less than all members, and (2) continuity of existence even though some members withdraw or die.

It would seem that if the Kintner plan of association is followed quite carefully in the drafting and the formal actions taken, clinics should not encounter too much trouble and that physicians who wish to set up retirement plans can now be encouraged to do so.

The Wisconsin Department of Taxation has not indicated what its position would be regarding the Kintner type association. Wisconsin might treat the group as a partnership for tax purposes and not recognize the retirement plan. The advantages for federal income tax purposes would in most cases outweigh any such views of the Wisconsin income tax authorities.

You will need the help of a lawyer and tax accountant if you decide to go ahead with an association and retirement plan.

DO YOU EMPLOY FOUR OR MORE PERSONS?

If you do, then you must pay unemployment insurance taxes.

Employers, including physicians, who employ four or more persons for some portion of the day on at least one day in each of 20 weeks in a calendar year are subject to both the state and federal unemployment insurance tax.

The combined state and federal tax is 3% of the first $3,000 of annual wages paid to all employees, of which 2.7% is payable to the state and 0.3% to the federal government.

The report and payment to the federal government is due by January 31 of the subsequent calendar year. Reports and payments to the state are due quarterly during the year in the months of April, July, October, and January. The exact date within the month is set by the state. These reports and payments are due regardless of whether the employer has been notified by either of the governments or has received tax forms.

If a physician or clinic has employed four or more persons in any portion of each of 20 weeks during the current year and has failed to pay the quarterly payments to the state, this should be done promptly so as to keep at a minimum any penalties and interest which will be due. Payment of the federal unemployment insurance tax should be made by January 31.

Special First Year Depreciation Allowance

You can write off up to $4,000 of the cost of business and professional property in the first year because of a new federal income tax law passed by Congress in 1958. In addition, you get your regular depreciation allowance the first year on the balance after this write-off.

The new law allows a 20% deduction in the year of purchase of new or used depreciable business assets, other than buildings and land improvements. You do not get any 20% write-off on any purchases in excess of $10,000 for a single taxpayer, or $20,000 for a taxpayer filing a joint return.

Suppose you buy a new item of equipment on January 2, 1958, costing $5,000 and that you file a joint return with your wife. You get an immediate deduction of $1,000. This equipment now has a basis for depreciation purposes of $4,000. Assuming it has a useful life of 10 years, you could get a regular first year's depreciation allowance of 20% of $4,000, or $800, if you use, for example, the 200% declining balance depreciation method. Thus, your total depreciation write-off in the first year is $1,800 of the total $5,000 purchase price.

If you are in a 50% federal tax bracket, this means that you have cut your net cash outlay for the equipment to $4,100.

You get the full 20% first year's write-off, regardless of when during the year you purchased the asset.

The law spells out certain technical rules:

1. The property must have a useful life of at least 6 years. This could mean that business automobiles are not eligibile for the write-off.
2. The property must be bought after 1957.
3. The write-off does not apply to so much of the basis of the new property as is a carry over of the basis of trade-ins. For example, assume the new equipment costs $5,000, but you pay $3,500 cash plus your old equipment, which had a basis to you of $750. Even though your new equipment has a depreciation basis of $4,250, the 20% write-off applies only to $3,500.

This special write-off applies only to federal income taxes. Wisconsin does not have a similar rule.

PLACEMENT SERVICE AIDS DOCTORS AND COMMUNITIES

Do you want an associate? Generalist or specialist? Do you need a locum tenens? Then call ALpine 6–3101 or write Box 1109, Madison 1, Wisconsin.

The placement service of the State Medical Society has helped many physicians find a new assistant, found promising locations for young practitioners, and brought resident medical service to many communities without a doctor.

Here is how the placement service may be able to help you. The Society maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Usually there are 30 to 50 generalists listed and a total of 80 to 125 specialists in all categories. The Society also maintains a list of physicians and communities offering opportunities to the physician in locum tenens, individual, group, and other types of practice. *The Wisconsin Medical Journal* offers to carry up to one inch of advertising copy for two months without charge when the advertisement is placed by an individual member of the Society. Reasonable rates apply to advertisements by clinics and others.

Physicians who have used the placement service have described it as one of the most effective in the United States. Journal advertising, too, has proved highly successful.

One word of advice: Advise the Society of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

25 pointers to prevent malpractice

These do's and don'ts are your best defense against malpractice

Recently, at a county medical society meeting, an indignant physician growled, "When is the State Medical Society going to do something about malpractice insurance?" He had just received his premium notice. It was $30 higher than the year before—and triple "what I paid 10 years ago."

A front-page headline in the local paper the same day declared: "Doctor Sued . . . Claim Wrong Medicine Given."

The intensity of the doctor's complaint is in direct proportion to the frequency of the headline—increased rates result mainly from more and higher suits. County, state, and national medical associations seem to be between the devil and the deep blue sea. Doctors plead for a state-wide group malpractice program. Some states have tried it; haven't been happy with the results. Here and there, a plan works—for a while. The Wisconsin Academy of General Practice announced at its 1956 annual meeting that two companies it had interested in group malpractice insurance had backed out. Scared. The American Medical Association has spent one full year studying the problem. A special committee has asked for at least another year before reporting to the House of Delegates.

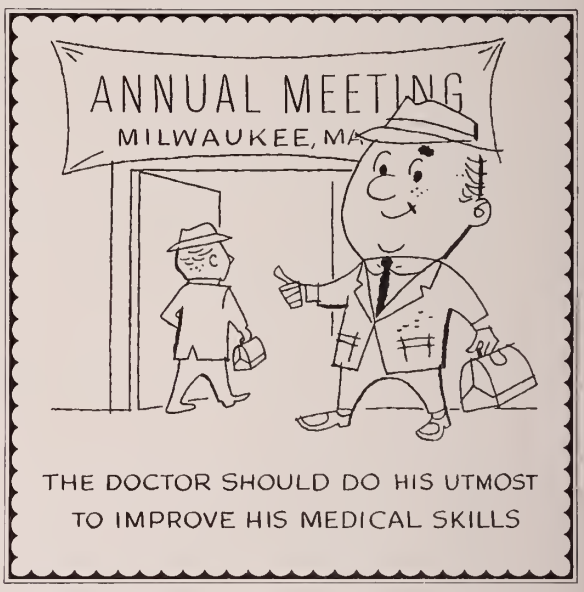
What's going on to create this furor about malpractice? Answers and ideas are a dime a dozen but the situation boils down to this:

The incidence of malpractice claims is 15 times greater today than it was ten years ago. Malpractice suits are contagious. Right or wrong, each malpractice suit breaks down further the public's confidence in the medical profession, leading to even more suits. Lower rates for malpractice insurance will be hard to come by.

In the final analysis, the doctor's best defense against malpractice and rising insurance rates is prevention.

Here are a few fundamentals to understand and remember:

*Any patient may bring a malpractice action against any physician who has attended him professionally. Most malpractice suits are without merit, but the damage is done with the first accusation.



*Know the legal interpretation of malpractice. The law requires that in diagnosing or treating a patient, you must possess the skill and exercise the care commonly possessed and exercised by other reputable physicians in the locality. If you call yourself a specialist, you must meet the standards of practice of a specialist in your field. These things are true even if you render your services without charge.

*The standard of practice is always determined by what other reputable physicians in the community, or in similar communities, would or would not do in the care of similar cases. Because medicine is not an exact science, not all patients who receive medical treatment get well. Considering each patient as an individual, there are few if any conditions for which there is a specific, single, universally recognized remedy or procedure. There is often room for honest difference of opinion. A mistake in diagnosis or an error in judgment may be recognizable only as a matter of hindsight. In the exercise of your best judgment, you may use medicines or methods of treatment different from those of some of your colleagues; and you may get different results. However, the mere fact that a patient is not cured or does not

progress favorably does not suggest culpable ignorance or negligence on your part. The main point to keep in mind is to exercise the ordinary skill and care required in the treatment of your patient. A malpractice charge is justifiable only if you have not done something you should have done or have done something you should not have done in terms of accepted standards of practice.

*The personal relationship between the physician and patient often determines whether or not an action is brought. Patients who have had a frank and full understanding of their ailments and treatment and who believe that everything possible has been done for them are not so likely to sue for malpractice—even though the results may have been death, unusual and unexpected physical change, or disability or continuing complications. According to surveys by several state medical societies and the American Medical Association, malpractice suits more often arise when the patient believes he has not been carefully attended; when he is resentful of some words or deeds of the physician, and others who attended him; or when some third person, either physician or nonmedical person, raises some doubt in his mind as to the propriety of the treatment. Emotional and psychological factors are obvious danger points to the physician-patient relationship. In these days of widely publicized "miracle cures," patients are likely to expect more dramatic and highly successful results than might be expected in the average case. The treatment of burns and fractures, tonsillitis, and appendicitis is generally regarded by the public as so routine and simple that any undesirable results are regarded as the basis for malpractice. Despite serious injury, a patient is likely to expect modern science to restore full motion to battered limbs or beauty to previously unblemished surface tissues. In physician-patient relationships, first impressions are the strongest. That's why it's so important for the physician to do everything in his power to develop an honest, frank, and psychologically sound relationship with his patient from the very first contact.

It is unfortunate that a physician cannot be satisfied with merely practicing good medicine. Knowing his legal duty to his patient, he must fulfill it and, at the same time, act in such a way as to anticipate an unjustified claim of malpractice in every act of treatment.

Here are 25 check points in malpractice prophylaxis. They will help the physician avoid legitimate malpractice, prevent the filing of unjustified claims, and protect him in the event of an unjust claim:

1. **The physician should be meticulous in providing every patient with care that meets the requirements of good medical practice.** He must possess the degree of skill possessed by other reputable practitioners in the same field of practice. He should do his utmost to maintain and improve those skills through postgraduate medical education. He must, in addition, exercise the degree of care, diligence, and judgment commonly and ordinarily exercised by other reputable members of his profession in similar circumstances.

2. **Avoid any criticism of the work of other physicians before the patient.** At least 65% of all suits are said to originate in criticism to the patient about treatment by another physician.

3. **Criticism of one physician by another is legitimate only when full facts are gathered from all parties.** At that point the discussion should take place privately between these physicians or within recognized legal or medical bodies. Use discretion in speaking to nurses, interns, or residents concerning the nature of the disease in the course of treatment. Unexplained casual remarks may produce fear or suspicion.

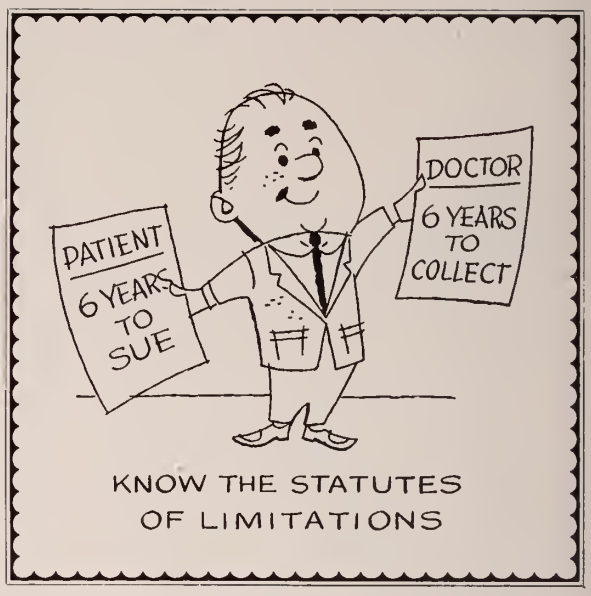
4. **Maintain adequate medical records on every case.** A good case record should include a medical history, a report on physical examination of the patient, and copies of all reports of laboratory work done. These data generally serve as the basis for a working diagnosis. If the diagnosis is not possible, consultation is desirable. Consultation reports must be in writing. Thereafter, a good record will include progress notes to pro-

vide a continued history of the case, its complications and sequelae; instructions to the patient; and the prescriptions given. The record should indicate what was done and when it was done. It should clearly indicate that nothing was neglected and that care was given to meet the standards demanded by the law. Copies of any special forms and of reports used or made in a particular case are also a part of a good record. All records should be maintained by the physician as if he were anticipating the likelihood of offering them in court at a later date. If a patient discontinues treatment before he should or fails to follow the physician's instructions, the record should show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course he is choosing.

5. **Avoid making any premature statement which might be construed as an admission of fault on your part.** A single careless statement might create liability for damages where actually no liability exists. Even though good practice may have been followed throughout the course of treatment, offhand remarks may be made under emotional stress to the partner, assistant, office nurse, patient, or his friends. The effect of such a remark when reported to a jury is incalculable and almost impossible to counteract. Further, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony. Similar admissions might be made by an agent or an employee of the physician during the course of treatment and within the scope of the employment. It is important to instruct employees to make no such statements at any time.

6. **Use large and frequent doses of tact.** You should maintain a proper professional manner and sound attitude toward both the patient and the patient's family at all times. Tact is most important in the discussion of fees. It is invaluable in avoiding over-optimistic prognoses, and especially any promise that would seem to be a guarantee of a particular result. Most of all, tact is essential to avoid the betrayal of privileged communications.

7. **Do not hesitate to use consultation.** You must be especially alert to sense early dissatisfaction and disturbing emotional undercurrents. If the patient is not doing well, consultation may be suggested. If the patient is dissatisfied or complaining or if the family's attitude indicates dissatisfaction, consultation should be demanded. If consultation is suggested by the family or the patient, you should accept it promptly and graciously. The use of a consultant may give you your best protection against a malpractice claim.



8. **Do not be hesitant to discuss fees and arrive at an understanding.** Grievance committees throughout the nation report misunderstanding on fees as the most frequent cause of complaint. No doubt fee problems trigger a high proportion of malpractice claims.

9. **Think twice before using pressure to collect fees.** A good physician is also a good businessman, but his attitude in collection must always be more professional than commercial. Be wise and cautious in your methods of collecting fees. The patient who is slow to pay his bills might be unusually quick to respond to suit by a counterclaim based on a groundless charge of malpractice. Therefore, the physician will do well to wait for three years before commencing an action for his fees. Although the patient may still argue that the treatment was so far below professional standards as to be noncompensable, at least he will be barred from basing a malpractice claim on the treatment given.

10. **Know the statutes of limitation.** In Wisconsin, the patient, in order to claim damages against his physician for malpractice must bring suit within three years of the alleged event. The same rule applies in those situations where the patient is sued by the physician and where, were it not for the statute of limitation, the patient might assert malpractice as ground for a counter-

claim for damages against the physician. Ordinarily, a suit for unpaid salary, wages, or other compensation for personal services must be brought within two years; but fees for professional services are not so limited. Instead the physician has six years in which to bring suit for fees. In any event, keep these statutes in mind before you press for payment of fees.

11. **Do not neglect or abandon your patient.** You are not legally obligated to accept the care of any patient. But once you assume that responsibility, you must see that the patient has the care and treatment required by his condition until the time you are discharged or withdraw from the case. If you decide to withdraw from a case, you are legally bound to give the patient reasonable notice of your intention and allow him the opportunity to replace you.

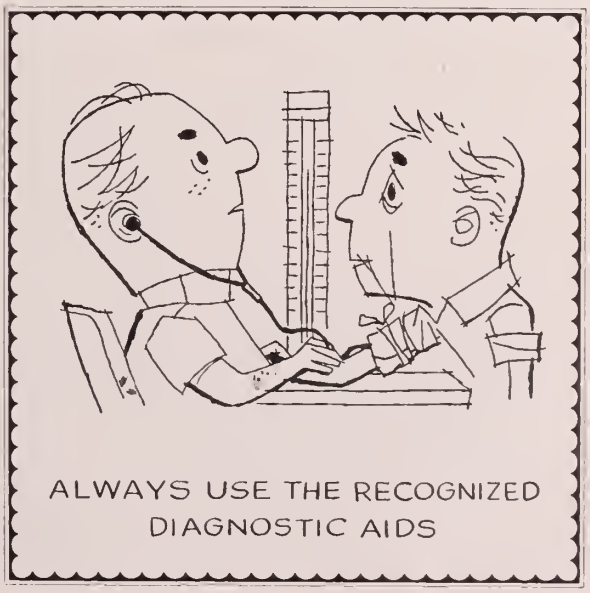
12. **You may, by the use of a notice or special contract, limit the services you agree to render.** For example, you may agree to treat the patient only at a certain place or for a limited time or for certain conditions. Conversely, your obligation increases if you make an express agreement or promise that you will effect a particular result. In other words, you must fulfill the terms of any special contract you might make. Remember, also, that the mere act of accepting a patient does not insure results, unless you commit yourself by specific promise.

    Once you have accepted the care of a patient, you must proceed diligently and without unnecessary delay. If for some reason you will be unavailable to your patient for care that he might reasonably require, you must make adequate provision and issue proper instructions (consistent with the standard of practice) for the care of the patient in your absence. You should advise your patient of any intended absence from practice and should recommend or make available a qualified substitute. You must also issue proper instructions for the protection of those coming in contact with the patient, such as family members, relatives, and nurses' aides.

13. **Limit your practice according to your qualifications.** Let your qualifications be your guide in selecting patients. Self-assurance is desirable, if not vital; but overconfidence and arrogance are dangerous. The ready use of consultation or assistance is substantial protection against malpractice.

14. **You must find or anticipate any condition reasonably determinable or reasonably likely to develop.** This means you must give your patient sufficient attention to give you the opportunity to know his true condition. You should always utilize recognized diagnostic aids as indicated by the condition—blood count, Wassermann, pregnancy test, culture, smear, urinalysis, stool examination, or x-ray (original or follow-up). You should take every precaution to make a complete diagnosis and to discover a reasonably determinable condition. Do your utmost to utilize an indicated prophylactic measure (antitoxin, for example), give instructions as needed, follow up the original treatment or operation, and institute measures to protect contacts. A common allegation in malpractice action is failure to use the x-ray at all or failure to make sufficient use of the x-ray. Whenever a fracture which was not diagnosed is present and no x-rays were taken, the conduct of the attending physician is likely to be condemned as not coming within the standards of good practice. Whenever a bad result, deformity, or limitation of motion occurs, your defense is immeasurably strengthened by the possession of a series of x-rays taken at intervals during the progress of the case. Should your patient refuse to have an x-ray made, you should immediately fortify yourself with the strongest written evidence. X-ray records, as well as the entire case record, should be carefully preserved beyond the time during which a malpractice suit may be brought.

15. **Remember: you are liable for the acts of others.** A physician may reasonably delegate



responsibilities not requiring professional judgment, but he should do so with great care and should carefully supervise his assistants and employees. There are many instances in which you may be responsible for the negligent acts and omissions of others as well as your own. For example, you are responsible for the acts of your assistants and employees, for any negligence on their part occurring during the course of their employment. If you practice with another physician as your partner, each partner is liable not only for his own acts and those of his partner but for the negligent acts of any agent or employee of the partnership.

When two independent practitioners are caring for a patient, each is liable not only for his own acts but for doing nothing about the negligence of the other which he has observed or, which in the exercise of ordinary diligence, he should have observed. As the attending physician, you are not generally liable for the negligence of an intern, a nurse, or other hospital employee. You are, however, responsible for the acts of the hospital personnel in so far as they are carried out under your immediate supervision and control. Thus, the operating surgeon, and not the hospital, is held liable for any negligence of operating room attendants during the performance of surgery.

16. **Keep the professional secret.** There are strong legal and ethical reasons why you should keep inviolate all confidential communications between you and the patient.

This is explained in greater detail in the article on the professional secret on page 34.

17. **It is extremely hazardous to sterilize any patient except when a positive medical indication exists.** There should be no promise or guarantee that the patient will be sterilized as the result of the procedure undertaken. If sterility is a likelihood or possibility as a result of contemplated surgery, you should explain that probability and obtain a signed authorization from both spouses.

18. **Do not examine a female patient unless a third person is present.** The only exception is an actual emergency. There is no more serious or destructive charge than that of undue familiarity. The only way to avoid claims of this sort seems to be to have someone else present during all such examinations.

19. **Don't experiment.** In the treatment of the patient, the physician must not experiment. In all diagnosis and treatment, he must follow good practice and common practice.

20. **Confirm prescriptions in writing.** Written prescriptions are advisable. Because of the increased possibility of error in transmission by telephone, it is always advisable to confirm such prescriptions in writing.

21. **Check your equipment.** Make a frequent check of the condition of your equipment and utilize all available safety installations. X-ray machines, diathermy equipment, and

Patient fails to carry out advice

Midville, Wis.
Jan. 1, 1957

Mr. Robert Jones
Midville, Wis.

Dear Mr. Jones:

At the time of my examination of your ankle this afternoon, I advised you of the desirability of having x-rays made. This you refused to do.

Upon your insistence that I treat your ankle and foot, without benefit of x-rays, I agreed to do my best in the circumstances, but as I advised you this afternoon, and must repeat now, I cannot establish, without x-rays, whether or not you have incurred a fracture.

In your own interest, I urge that you have an immediate x-ray study made of your foot and ankle.

Yours very truly,

John Brown, M.D.

Substance of letter to patient to be changed to fit the particular facts and circumstances. Carbon copy, with proof of mailing of original written thereon, to be filed with medical case record.

Patient fails to keep appointment

Midville, Wis.
Jan. 1, 1957

Mr. Robert Jones
Midville, Wis.

Dear Mr. Jones:

My records indicate that you failed to keep your appointment of December 31, and that you have not made any subsequent appointment or appearance in the office.

In your own interest, may I call to your attention the fact that further professional attention, is in my opinion, definitely needed. If there is some reason why you prefer not to return to this office, I urge that you immediately seek other competent professional care. I shall be glad to give the benefit of my knowledge of your case to your subsequent physician, should you elect to receive the needed attention at other hands.

John Brown, M.D.

Yours very truly,

When a patient fails to keep an appointment, or discontinue treatment before he should, it is desirable to send him a letter, incorporating the pertinent facts and the recommendations. File a carbon copy, endorsed with a certificate of mailing, with medical case record. Registered mail may be used.

Patient discharges physician from case

If a physician justifies his failure to continue in attendance upon a patient upon either his having withdrawn from the case or of having been discharged by the patient, the burden of proof of such contention is upon him—hence the desirability, if not the actual necessity, of having written evidence available.

Midville, Wis.
Jan. 1, 1957

Dear Mr. and Mrs. Jones:

This is confirmation, and my acknowledgment, of the fact that you have, as of this date, discharged me from further professional attendance upon you in your current illness.

Should you desire, I shall be glad to cooperate with the physician you now call, in supplying him with such information as I have gained in respect to your case.

Yours very truly,

John Brown, M.D.

Physician withdraws from case

Midville, Wis.
Jan. 1, 1957

Mr. Robert Jones
Midville, Wis.

Dear Mr. Jones:

You have repeatedly failed to follow my advise and recommendations.

I am therefore advising you of my intention to withdraw from further professional responsibility in connection with your case. To allow you a reasonable opportunity to secure another physician, I shall be available, at your request, to render you service for three days from your receipt of this letter, but not thereafter. In this period of time, in this community of several hundred physicians, you can readily fill my place.

I shall be glad to give, to any reputable physician of your choice, the benefit of such knowledge as I have gained of your case.

Yours very truly,

John Brown, M.D.

A physician may withdraw from attendance upon a patient, but he must give reasonable notice of his intention to do so and must allow the patient reasonable time and opportunity to fill his place. It is desirable that written evidence be available as to the withdrawal and the reasons therefor.

It is a serious question of judgment, whether, when a patient fails to cooperate or refuses to follow advice, the physician should continue on the case. It is recommended, that, if the physician decided to continue to care for an uncooperative patient, who, for example, refuses to have an indicated x-ray study made, he should demand and require consultation.

Letters should be sent and carbon copy filed. The wording should be simple and direct, but the intent and meaning must be clear and certain.

Midville, Wis.

Jan. 1, 1957

1. I hereby authorize and direct Dr. _____ to perform the following operation upon me _____ and to do any other procedure that (their) (his) judgment may dictate during the above operation.

2. I understand that the surgeon (surgeons) will be occupied solely with the surgery, and that the administration and maintenance of the anesthesia are independent functions, and will be in charge of Dr. _____. I consent to the administration of such anesthetic, or anesthetics, as Dr. _____ may deem advisable in my case.

3. It has been explained to me that I may be sterile as a result of this operation, although no such result is warranted or guaranteed. I understand what the term sterility means and, in giving my consent to the operation, I have in mind the possibility (probability) of such a result.

4. I join in authorizing the performance, upon my (husband) (wife), of the surgery consented to above. It has been explained to me that, as a result of the operation, my (husband) (wife) may be sterile.

Signed _____

Witness _____

Hour _____ A.M. P.M.

Consent to operation

** Cross out paragraphs not applicable to particular case.*

Place_____

Date_____

1. I (we) being the parent(s), guardian, custodian of a minor of the age of ___, do hereby authorize and request Dr. _____ to perform such surgical operation on the person of said _____, a minor, as the judgment of said Dr. _____ may dictate.

2. I (we) also authorize and request the employment of such anesthetic or anesthetics as may be deemed suitable in the judgment of the said Dr. _____, or in the judgment of the anesthetist selected to administer the anthestic or anesthetics in this case.

Signed _____

_____

Witness _____

Hour _____ A.M. P.M.

Consent to operation on a minor

A similar consent form may, and should, be used in the case of a patient who is incompetent; signed by guardian, custodian, or other person legally responsible for the incompetent.

similar devices utilizing electrical or chemical processes should be most closely watched.

22. **Be sure to get written consent for operations.** Any adult in a clear state of mind may authorize operation upon himself. Oral consent might be considered sufficient; but because of the difficulty in proving that it was given, physicians should invariably request a witnessed consent in writing. If the patient is a minor (under the age of 21), consent is to be obtained from the parent or guardian. If the individual is mentally incompetent, the consent of the one who stands in the position of guardian is required. When an operation is made compulsory by law (such as vaccination or sterilization), the law furnishes the consent. If an operation is unlawful, consent to the performance thereof does not absolve the surgeon from liability.

    In an emergency which demands immediate action for the preservation of the life or health of a patient and in which it is not practicable to obtain his consent or the consent of anyone authorized to speak for him, it is your duty to perform without consent such operation as good surgical practice demands.

    Special attention should be given to operations which might or are likely to result in sterility. The trend of cases in recent years indicates that it is extremely unwise to pursue a course of treatment that is self-hazardous or capable of producing harmful effect without securing a written statement from the patient or from someone legally responsible for the patient—a statement which clearly expresses understanding of and consent to the specific treatment.

23. **Consent is required for autopsy.** You must secure consent to perform a postmortem examination. You should most certainly have this in writing. It should be sufficiently comprehensive to allow the removal and taking away of tissue if such is to be done.

24. **What to do if called as a witness.** Always secure legal advice if you are called to attend a coroner's inquest as a witness in a case in which you have been in professional attendance. The same would hold true whenever you are called as a witness in some case in which you have been the attending physician, assistant, or consultant.

25. **Don't talk about your malpractice insurance.** You should not reveal to your patient or his family that you carry professional liability insurance. You should not (except on the recommendation of your legal advisor) write a letter or make any statement with reference to a malpractice claim. Immediately on being advised of even the possibility of a suit, you should consult with your attorney.

You can't entirely prevent a malpractice suit. You can only know your own rights and those of the patient, conduct your practice as best you know how, and continually keep up your guard against an unjust malpractice accusation.

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7. Wis. Statutes, Section 330.205.
8. Wis. Statutes, Section 330.27.
9. Wis. Statutes, Section 330.21 (5).

CHEMICAL TESTS FOR INTOXICATION

Chemical tests for intoxication are legal in Wisconsin.

Samples of breath, blood, urine, or saliva may be taken and analyzed to determine the sobriety of a person operating a vehicle or handling a firearm. The results of the analyses are admissible as evidence in court cases and other legal proceedings.

Sobriety will be deemed proved—if a sample taken within two hours of the event shows only 5 one-hundredths of 1% or less by weight of alcohol in the blood. Other evidence to the contrary may affect or change the presumption, however.

Intoxication will be presumed—if the alcohol concentration is 15 one-hundredths of 1% or more. Other contrary evidence may upset this presumption.

No presumption is created—by alcohol concentrations between these two ratios, or if the sample was taken more than two hours after the event. However, an expert witness may testify that even these tests prove sobriety or intoxication.

Blood Transfusions—Medicolegal Responsibilities

ALTHOUGH the blood transfusion is now generally considered to be a relatively minor procedure, it is nevertheless responsible for a significant number of medical accidents each year throughout the United States. The technique has become so routine that many physicians have a tendency to disregard the inherent dangers that accompany blood and plasma transfusions but that are not usually present in other intravenous procedures. It has been estimated that the mortality due to blood transfusions is about one death in 1,000 to 3,000 transfusions. It has also been estimated that as many as 3,500,000 transfusions are given each year in the United States. As a cause of death, the blood transfusion ranks with appendicitis or anesthesia. Yet, despite these facts, blood transfusions have been given by some physicians merely to facilitate the more rapid recuperation of a "run-down" patient, without even the suggestion of an emergency. Inasmuch as the transfusion of blood is associated with significant medical and legal hazards, such treatment should be prescribed only in instances in which it is essential for the patient's recovery.

It would seem to go without saying that accuracy in blood grouping and cross-matching tests is fundamental to a safe blood transfusion. In giving a blood transfusion, the physician, of necessity, must frequently rely entirely upon the laboratory. If blood is incorrectly grouped or cross-matched by the laboratory the physician has no way of correcting the mistake. Therefore, the utmost care must be taken to provide precautionary measures in the laboratory that will minimize the possibility of errors. Those in charge of such laboratories should entrust grouping and cross-matching tests only to reliable and specially trained technicians. Many of the accidents that have occurred are directly attributable to untrained interns and physicians who performed these tests at night or on holidays, in the absence of regularly assigned technicians.

Even when grouping and cross-matching tests are performed by highly skilled persons, labels are sometimes switched or bottles of blood mislabeled. A transfusion accident is practically inevitable once a bottle of blood has been mislabeled. Accidents occurring because of mislabeling seem to be just as prevalent as those resulting from errors in blood grouping or cross-matching. Besides errors in blood grouping, accidents occur because of clerical errors or sheer carelessness, as in the case in which one of two patients with similar or identical names may require a transfusion and blood is administered to the wrong person. If a patient suffers a prolonged illness or dies as a result of a transfusion of blood of an incorrect group, the patient, or his family, if he does not survive, may be entitled to damages unless the immediate need for blood to sustain life allowed no time for adequate tests. The transfusion of blood of an incompatible group is prima facie evidence of negligence and legal liability.

Undoubtedly, transfusion of blood of an incorrect blood group occurs far more frequently than is recorded in the published, reported court decisions, since, generally, only the decisions of appellate courts are reported. Then, too, not all the accidents that occur mature into claims; most claims are settled out of court and those that go to trial are appealed infrequently. However, the number of court decisions that have been reported, particularly within the last five years, offers convincing evidence that blood-transfusion accidents are not isolated occurrences.

A number of medical, social, and legal conclusions can be drawn from a study of the recent cases involving blood transfusions and the taking of blood —all of which are interrelated and interdependent.

From a medical standpoint, the taking and transfusion of blood have evolved from difficult to relatively simple techniques, while at the same time the number of accidents has apparently increased appreciably. This is characteristic of medical progress, for as the number of lifesaving procedures increase the number of accidents likewise tend to increase even though the ratio of accidents to treatment may remain constant or even diminish.

The compensation of injured persons at the expense of those who are deemed responsible is determined fundamentally by the social philosophy of the courts and justified by legal doctrines. Most lawyers will acknowledge the pliability of the law applicable to personal injuries and the manner in which the courts use legal doctrines to accommodate their conceptions of social justice. More and more it is evident that the courts are relying upon recognition of an underlying principle of risk distribution, and this is reflected in the frequency of verdicts for the plaintiff.

No hospital, even if it is a charitable hospital that is operated in a jurisdiction that holds such institutions to be immune from tort liability, can afford to be without insurance coverage in the face of ever-broadening liability.

When effective ways are discovered to eliminate the legal problems that arise out of accidents in blood transfusion and similar accidents, it will be physicians and not lawyers who will lead the way by devising fool-proof techniques that will avoid such errors as mistakes in blood-grouping or label-switching. In some of the grey areas the use of good medicolegal forms will offer a measure of protection. However, in the final analysis these legal problems can be dealt with adequately only if medicine will provide similar emphasis upon accident prevention and the utilization of already acquired knowledge as it does to scientific advancement, for true medical progress can only be measured by the preservation of life.—*Reprinted, in part, from J.A.M.A. Vol. 163, No. 4, January 26, 1957.*

What Every Doctor

WORKMEN'S

The Wisconsin Industrial Commission is shown above reviewing and editing the following article in its early stages of preparation. Left to right are Ralph E. Gintz, director of the Workmen's Compensation Division; John H. Rouse; R. G. Knutson, chairman; and A. W. Enright.

Information about the Workmen's Compensation Act is news of direct interest to virtually every physician in Wisconsin, irrespective of his specialty or location.

The law applies to more than 70,000 employers who have three or more employees. Farmers are excluded. If any one of the more than one million employees covered by the act receives an injury or disease during the course of his employment, the law makes the employer liable to provide certain indemnities and to provide or pay for such medical attention as may be needed to bring about rehabilitation.

Five points of advice will aid every physician in dealing with Workmen's Comp.:

★ Have your name listed on the State Medical Society's Workmen's Compensation panels if you want to treat employees under Workmen's Compensation.

★ Learn how to estimate disability according to the standards set up by the Industrial Commission of Wisconsin. Other standards or schedules are fine for your own information, but only the Commission's standards are authoritative in Wisconsin.

★ Submit your reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and professional fees to the physician. Quite often the unexpected misfortune places the employee in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society, Box 1109, Madison 1, Wisconsin, or Mr. R. E. Gintz, Director of Workmen's Compensation, State Office Building, Madison 3, Wisconsin.

The following article provides answers to the questions most commonly asked of the State Medical Society in its past 22 years of experience with the Workmen's Compensation Act.

Should Know About

COMPENSATION

Q. Since the Workmen's Compensation Act is designed to provide protection to the working men of Wisconsin, how does the physician get into the picture?

A. When a workman has, or thinks he has, an injury or disease resulting from his employment, a report from the employer or a claim by the workman is filed with the Industrial Commission, Inc. To establish this claim a medical report verifying and specifying the workman's injuries or diseases and the degree of disability is necessary. The Industrial Commission and the employer or insurance company use the doctor's disability report to help determine the amount of compensation. If it turns out that the employer is obligated to provide or pay for necessary medical attention, he may be required to supply the injured employee with "such medical-surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial limbs and appliances. . . as may be reasonably required to cure and relieve the effects of the injury."

Q. How does the Industrial Commission determine whether the claim is justified?

A. Three essential elements must be ascertained before an award can be made to an injured claimant. They are an employer-employee relationship; the employer must be subject to the Act; and it must be proved that the injury or disease was suffered or acquired in the course of employment.

Q. Can any physician treat employees under the Workmen's Compensation Act?

A. Any licensed physician, as a general rule. The Workmen's Compensation Act requires the employer to maintain a "reasonable number" of competent and impartial physicians ready to undertake the treatment of his employees and to permit the employees to make a choice of their physicians from among them.

Some employers publish a limited type of list or panel of such physicians to whom their employees are expected to go for care. This is legal so long as the Industrial Commission agrees that the number of physicians listed is a "reasonable number." There is no set number. The Commission takes into account the community medical resources and needs.

Prior to 1939 a great many companies had limited panels. However, during that year the State Medical Society of Wisconsin and the insurance companies selling workmen's compensation insurance in the state entered into a joint agreement to enlarge the panels through the voluntary cooperation of employers and the insurance companies. The object was to give the workmen of Wisconsin an opportunity to secure virtual free choice of physician.

This agreement has come to be called the "Open Panel System." Any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employees may have his name included on the panel, which is prepared for each county in the state. These panels are certified to the insurance companies and are distributed to each employer of three or more persons in the state. This system has been so successful that more than 80% of the workmen in Wisconsin now have a wide choice of physicians.

Q. How does a doctor get on the panel?

A. Once each year the State Medical Society of Wisconsin circulates each of its members. The doctor is asked if he wants to be listed on the panel. If he completes the form and returns it promptly, he will automatically be listed for the current year.

Q. Does the doctor take on any obligations if he applies for a listing on the panel?

A. Yes. He agrees to have consultation when this is requested by the insurance carrier. He also agrees to communicate with the insurance carrier on the matter of choice of the consultant so that the consultant might be mutually agreed upon. Some exceptions will occur to these agreements, but the exceptions should be limited only to emergencies.

Q. Are any other practitioners listed on the "Open Panel"?

A. No. The panel lists only members of the State Medical Society. If any panel distributed by an insurance carrier contains the names of any other persons, it is not a panel approved by the State Medical Society.

Q. What happens in the event of dispute or complaint about the handling of certain cases?

A. Under the "Open Panel" agreement a "State Conference Committee" is set up. It includes two representatives of the insurance carriers and two representatives of the State Medical Society. The duties of this committee are to mediate, if possible, cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary, cases where insurance carriers are charged with having unreasonably interfered with what is properly in the discretion or control of the attending physician, and differences that may arise between the attending physician and the insurance carrier relative to remuneration; to review any situation in which it is claimed there is a violation of ethics; and to hear complaints relative to the competency of those serving on the panel and remove their names from it if an investigation shows that such complaints are justified. Cases involving medical ethics will be referred to the board of censors of the appropriate county medical society. Local committees may be designated to investigate and report back to the "State Conference Committee" with recommendations when it seems necessary. Mediation will be attempted only in cases in which the physician involved is on the listing provided by the State Medical Society.

Q. How is the physician paid for services rendered to an injured workman who is covered under the act?

A. Sometimes the employer pays. Sometimes the employee must pay. For example, if the employer himself authorizes the physician to treat the injured workman, that employer is directly liable to the doctor for the expense of the treatment. The employer's liability continues until such time as he terminates it by objecting to the provision of further medical care at his expense.

If, on the other hand, the injured employee himself requested the treatment, without authorization from the employer, the physician will get his payment from the injured employee. Ordinarily, however, he can expect the Industrial Commission to determine any part of that treatment for which the employer is responsible.

Q. What about other situations?

A. Where the employer fails to furnish a panel, the injured employee has complete free choice. Then the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible.

Sometimes the employee does not give notice of his need for treatment, or he refuses to accept the panel physician. Then the employer has no liability and the Commission no jurisdiction to determine necessity or reasonableness.

Q. Are the claim reports filed by the physician kept confidential?

A. As a general rule, communications from a patient to an attending physician are privileged and may not be communicated by him. But the Workmen's Compensation Act creates an exception to this law of privilege by providing that any physician who has attended an injured employee may be required to testify before the Commission when it so directs. Here's what the Commission has to say on this point: "It is a practical necessity that physicians attending injured workmen be permitted to furnish information to the Commission upon which compensation can be based. Physicians will not be required, however, to disclose confidential communications transmitted to them for the purpose of treatment unless such information is necessary to a proper disposition of the claim. The Commission regards the physician who treats the injured workman at the request of the employer to all intents and purposes as the physician of the injured man. His testimony before the Commission should be absolutely fair, factual, and unbiased."

Q. Does this mean that the physician need not divulge any information to the employer about an employee who files a claim?

A. The physician most certainly is not required to disclose information communicated to him by the employee when it goes beyond the information required for a proper disposition of a claim. However, under the Workmen's Compensation Act, the employer, the insurance company, or the Industrial Commission has the right to request a complete report on an injured employee. So, as a matter of fact, the physician may legally transmit to the employer such information as is required for a proper disposition of the claim. He is not privileged to release any other information than that ordinarily required for the handling of the claim.

Q. What is the doctor's role in disputed cases?

A. Naturally, there will sometimes be disputes between the employee and the employer or his compensation carrier as to whether the workman has suffered an injury in the course of his employment for which he is entitled to compensation. The physician may be asked to act as an expert witness for either the injured workman, the employer, or his insurance company. Of course, the physician may be involved because he was the attending physician. Therefore, doctors must be interested in the fact that the basis for any claim depends upon whether the injury or disease was suffered in the course of employment.

When the employer or his insurance company agrees to the fact that the injury or disease was suffered in the course of employment, the question then is confined to the extent of liability on the part of the employer. In many instances this means the physician must be prepared to explain the disability in terms of its effect on the employee.

Q. What about "outside" physicians appearing as expert witnesses?

A. Sometimes the injured workman calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such cases the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully. The Commission is authorized in the interest of a fair and impartial hearing to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians are witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Q. How much is paid as a witness fee when physicians testify?

A. Ordinary witness fees are paid unless the physician performs work in preparation at the request of one of the parties to the dispute. In the case of physicians who are called by the Commission as independent expert witnesses or for the purpose of simply making an examination and report, the Industrial Commission has an established fee schedule under which the services are rendered. At the same time the Commission recognizes that present-day conditions frequently warrant larger fees and these may be allowed.

The Commission's fee schedule does not govern the contractual relation between the physician and the claimant, and the physician and the employer, where the physician is called as the expert witness of either one. In those cases in which the physician appears as an expert witness for the injured employee, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employee through permitting only what it considers to be a reasonable allowance for the expert witness. Each bill necessarily depends on the circumstances of the individual case. The State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness. With an itemized statement before it, the Industrial Commission is in a better position to judge the work involved and the reasonableness of the charges of the physician.

Physicians must also keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employee for payment. Likewise, where a physician treats an injured employee, and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Q. Must a physician obey a subpoena when only ordinary witness fees are paid?

A. Yes. Some physicians believe that they cannot be required to obey a subpoena unless an expert witness fee is paid to them. This is erroneous. Wisconsin courts have held that, except where there is a demand for preparation, every witness, expert or otherwise, must obey a subpoena upon payment of the ordinary witness fee.

Schedule of Witness Fees

Unless otherwise specifically agreed, services of physicians and surgeons rendered at the request of the Commission shall be understood as contracted for on the following terms:

Minor examination and report, not to exceed	$ 5.00
Major examination and report, not to exceed	10.00
X-rays where necessary to foregoing examination and report, not to exceed an additional	5.00
Attendance at hearings on request of Commission:	
for first hour	10.00
for each additional hour	5.00

Claims for such services must be paid from the Commission's appropriation and should be submitted on official voucher blanks.

Q. Are there special procedures for the handling of compensation claims of state employees?

A. In a sense, yes. The Commission is particularly explicit in its demands for itemized medical statements and for verification of the reasonableness of the medical charges in the case of state employees who file compensation claims.

Such cases require a report (on a form supplied by the Commission) from the attending physician, showing the nature of injury and the extent of disability. In addition, the physician and/or hospital must provide an itemized bill showing services rendered and charges made. This need not be verified.

In any case in which disability results or medical expense is involved, a statement is required from the employee (on a form supplied by the Industrial Commission) to the effect that he was injured in the course of his employment, reciting time and place of injury, the reasons for its occurrence, and the nature of injury, and stating all expenditures incurred for medical, surgical, and hospital treatment and medicines to the time of the claim, whether the claim is made for disability and, if so, what period of temporary disability and what permanent disability is claimed, and what salary has been paid by the state during the period of disability. If bills have been paid by the injured, receipts are to be attached.

Further, these cases require a statement from the employing department stating whether injury oc-

curred in the course of employment and whether treatment is believed necessary as claimed. This will be made in conjunction with the employee's statement and on the same form. If the department is unable to make a statement, the reason is to be stated.

Q. How does the physician go about estimating permanent disability under the Wisconsin Workmen's Compensation Act?

A. When it comes to estimating permanent disability, injuries are divided into two types: non-schedule and schedule injuries. With so many physicians on the Workmen's Compensation panels treating injured employees, it is obvious the physician should have a clear understanding of these two types of injuries and how to estimate permanent disability. Doctors ought to study the benefit provisions of the Workmen's Compensation Act. Probably the best way to do this is to obtain a copy of the act in pamphlet form. Any interested physician can obtain this pamphlet upon request to the Industrial Commission.

Q. Can you explain non-schedule injuries?

A. Non-schedule injuries are those to some portion of the body other than the legs, arms, ears, or eyes, or their constituent parts. In other words, non-schedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

Permanent disability for such injuries is estimated on the basis of the comparison between the nature of *the injury* and the nature of *an injury* causing permanent total disability of the entire body as a working unit. For example, Wisconsin courts have held that the fact that the injured person suffered no actual loss of earnings did not deprive him of compensation for permanent disability based on permanent physical loss. The effect is to place so-called non-schedule types of injury in essentially the same category as schedule injuries as to method of determination of permanent disability.

Q. Now what is meant by schedule injuries?

A. Schedule injuries are estimated upon a different basis which bears no relation to wage loss. In these cases *the comparison is between the injured limb and a normal limb,* having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes, and ears, as well as any constituent part of these members and organs. Disability is measured as a percentage loss of use as compared to amputation at a designated joint or joints or, in the case of the eye or ear, as a percentage loss of use compared to total loss of sight or hearing.

The estimate of disability has no reference to any particular occupational use to which the member is to be put. For example, the violin player who has lost a digit vital for the purpose of playing may consequently lose a great deal in wages. However, he receives exactly the same number of weeks compensation as does the laborer who may be able to perform his work nearly as efficiently as before even with the loss of a digit.

The law fixes the value of each finger, thumb, toe, hand, arm, foot, and leg at various joints. In the estimation of disability the physician takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists. If disability is between joints, he considers the percentage of loss of function at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the injured arm with a normal arm at the elbow or, put conversely, with an arm which has been amputated at the elbow.

In every case of schedule injury where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases. Therefore, the estimate in such cases should be uniform. If the employee has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted. In case of schedule injuries the Commission has found it possible to establish by custom or rule the related disability applicable to a given handicap.

Q. Is there anything to help the physician in rating disabilities?

A. Yes. The Commission worked closely with the State Medical Society and physicians in establishing a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In this guide, for example, where the loss of the function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20% of the arm at the shoulder* (see guide on page 29).

In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. If, for example, in addition to limitation of motion, there is disabling pain and/or weakness, a percentage must be added for these elements. As the Commission has adopted these landmarks to measure disabilities only for loss of motion, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability. It should be clearly indicated at what joint or joints the disability is measured.

Q. What if the physician disagrees with these methods of estimating disability?

A. Most parties are in general agreement as to the essential justice of the current provisions. Obviously, the physician's methods of estimating must

Industrial Commission Guide for Estimating Disabilities

The following guide represents per cent of loss of use as compared with amputations at involved joints. This guide measures disability for loss of motion only. Other factors of disability such as pain, weakness, loss of sensation, etc., are to be established separately.

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Total ankylosis of arm at elbow at right angles	
With radio-ulnar motion intact	50%
With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle, and proximal joints	100%	100%

Fingers

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10%	= 1%	10%	= 2%
	20%	= 2%	20%	= 4%
	30%	= 3%	30%	= 6%
	40%	= 5%	40%	= 8%
	50%	= 10%	50%	= 15%
	60%	= 15%	60%	= 20%
	70%	= 20%	70%	= 30%
	80%	= 25%	80%	= 40%
			100%	= 60%
Middle joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 10%
	40%	= 25%	40%	= 15%
	50%	= 40%	50%	= 30%
	60%	= 50%	60%	= 50%
	70%	= 60%	70%	= 70%
	80%	= 70%	80%	= 90%
			100%	= 100%
Proximal joint only	10%	= 5%	10%	= 2½%
	20%	= 10%	20%	= 5%
	30%	= 15%	30%	= 15%
	40%	= 20%	40%	= 20%
	50%	= 25%	50%	= 25%
	60%	= 30%	60%	= 40%
	70%	= 35%	70%	= 75%
	80%	= 40%	80%	= 85%
			90%	= 100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis — favorable position 10°–15° equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

Physicians should submit their reports promptly to the Commission. Delay may mean withholding of compensation to the injured employee and of professional fees to the physician.

be in accordance with the law regardless of his personal feelings as to the correctness or justness of the law. Any feelings that the law is harsh, inadequate, or inequitable in certain individual cases should never be allowed to influence the physician either in treating or in estimating disability.

Q. Should the doctor suggest the basis for settlement?

A. No. The physician who estimates disability should never concern himself with the result in number of weeks or in dollars. He should confine himself strictly to the medical field in estimating the disability on a functional basis. It is the function of the employer and the carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. Obviously, the physician should not be influenced by the amount of compensation which may be paid to the injured.

Q. Does the physician have any part in the computation of compensation?

A. Physicians should not attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than a particular physician might consider to be equitable. Computation of compensation based on estimates of disability is a function of the Industrial Commission. The attempts of physicians to compute sometimes result in erroneous figures and cause confusion and misunderstanding, both on the part of the physician and the injured person.

Q. In estimating disabilities in the schedule group, would 50% loss of motion mean 50% loss of function of the limb?

A. No, not necessarily. Loss of use and loss of motion are not always identical. All functions of the limb, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, and so forth, must be considered. The physician must assign to each factor the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member. Also, to each factor must be applied the percentage of loss of motion of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

When disability consists of loss of motion of a finger, the physician need not convert the degrees or percentage loss of flexion or extension into loss of use as shown by the guide on page 31, since the Commission can do this from the information supplied. The physician should clearly set forth the degrees or percentage loss of flexion and/or loss of extension at each joint of each finger that is affected. Normal extension is in a position of 180 degrees at all joints. Normal flexion at the distal joint of the finger is taken to be 70 degrees in the absence of any indication to the contrary. At the second or middle joint, normal flexion is considered to be 100 degrees and at the proximal 90 degrees. For example, a 30-degree loss of extension at the middle joint is 30% loss of extension rather than 16%, which many physicians often indicate. This is true because 30% loss of extension must be a percentage of the total motion of the joint, in this case the middle joint, which has only 100 degrees of motion.

Q. What kind of forms are used in reporting disabilities under the Compensation Act?

A. The Commission has adopted special forms for use of physicians. If the Commission is to pass upon a disability, it is necessary that the physician's report contain all of the information requested on this form as a basic minimum. If for some reason the form is not used by the physician, he should make certain that the requirements of the form are met. This will save returning the form to the physician with a request for supplementary report.

Q. If the physician completes the form properly, does this eliminate the need for him to personally appear in cases before the Commission?

A. Approximately 90% of all injury claims are paid by the employer or insurance company without dispute and on the basis of reports submitted. Where dispute arises and formal hearing becomes necessary, the Commission has a type of physician's report form which may eliminate the necessity of having the physician appear personally. The law provides that the contents of verified medical and surgical reports by physicians licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima-facie evidence as to the matter contained therein, subject to such rules and such limitations as the Commission may prescribe. Likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom the claimant has been sent for examination and treatment by the employer or insurer, are available for evidence provided the doctor consents to subject himself to cross-examination. The use of the form mentioned above makes it unnecessary for the physician to appear personally in some cases, especially where the issue and dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of the hearing.

Q. Are special forms used in cases of loss of vision?

A. Yes. These forms will be supplied to physicians upon their request, along with rules for determining loss of visual efficiency caused by industrial injury.

Q. Are there any special forms for estimating loss of hearing?

A. In cooperation with the medical profession, insurance carriers, industry, and labor, the Commission has worked out formulas for determining the loss of hearing suffered during the course and as a result of particular employments. These formulas are a guide at the present time and are primarily for the assistance of the examining physician. Copies of the formulas and associated material may be obtained by writing the Commission.

Q. Are there any suggestions for completing the forms required by the Commission?

A. The Commission needs a full report covering all factors if it is to be able to fix the percentage of disability. Therefore, the doctor should set out in detail the elements which constitute disability. He should state as nearly as possible the weight and percentage of loss which has been ascribed to each. He should also set out his opinion as to the ultimate total percentage of disability which has resulted. This enables the Commission to check the report with its standards and to arrive at an intelligent and uniform conclusion.

Q. What about terminology?

A. Many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring, and little fingers, and to disability at the distal, second, and proximal joints. Some physicians refer to the first, second, third, and fourth fingers, and some designate the thumb as the first finger. Some physicians speak of the interphalangeal joints, and sometimes of the first, second, and third joints, leaving confusion as to the point of measurement. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reports can be avoided.

Q. Can a physician use his own standard for measurement of disability?

A. No standards or schedules not adopted by the Commission have the approval of the Commission. Only those adopted and published by the Commission itself should be considered as authoritative or as representing the Commission's thought as to percentages of disability based on certain functional losses. Obviously, physicians will have various ideas as to standards and schedules for estimating disability. However, they should use these as a matter of interest. Their opinions should be based upon their own examination and analysis and by reference to the standards which the Commission has adopted.

Q. To whom should the physician furnish reports with regard to a compensation claim?

A. Regardless of any other statutory provisions, the law specifically provides that any physician attending a Workmen's Compensation claimant may furnish to the employee, employer, Workmen's Compensation insurance carrier, or the Commission information and reports relative to a compensation claim. It further provides that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Q. How does a physician get the needed report forms?

A. Simply write to the Industrial Commission, State Office Building, Madison 2, Wisconsin.

Q. Where can the physician go for additional help in handling compensation cases?

A. The Workmen's Compensation Act and its administration is necessarily highly technical. The panel physician will find it easier to deal with the employer, the insurance carrier, and the patient if he has a reasonable understanding of its operation. Both the office of the State Medical Society and the Industrial Commission stand ready to assist in solving some of the problems facing the physician who treats patients entitled to or claiming benefits under the act. Inquiries may be directed either to the State Medical Society, Box 1109, Madison 1, Wisconsin, or to Mr. R. E. Gintz, Director of Workmen's Compensation, State Office Building, Madison 2, Wisconsin.

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Consent for a physician to conduct a post mortem examination is considered sufficient when it is given by the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

TAKING THE WRAPS OFF THE PROFESSIONAL SECRET

Say the wrong thing about your patient and you may lose your license. But some things are not so secret. Here's the story.

THE television guessing game, "I've Got a Secret," must make the doctors smile. With the possible exception of the clergy and the social security administration, the doctors of America probably have more secrets in safe deposit than anyone else.

Quite unlike the television program, which rewards the participant for his risk of exposure, the doctor has both a legal and ethical duty to keep secret what he has learned from or about his patient in the course of professional treatment.

Two sections of the Wisconsin statutes speak out pretty strongly on confidences entrusted by patients to a physician:

1. Willful betrayal of a professional secret is ground for revocation of a physician's license. In other words, never speak about your patient's affairs unless you have the express consent of the patient himself or of someone identified by competent legal authority as empowered to consent for him, or unless you are commanded to speak by the presiding judge of a court.
2. No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only (1) in trials for homicide when the disclosure relates directly to the fact or immediate circumstance of the homicide, (2) in all lunacy inquiries, (3) in actions, civil or criminal, against the physician for malpractice, (4) with the express consent of the patient, or in the case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition. This is the section which gives "privileged status" to communications made by a patient to his physician and is of primary importance to the patient himself or his attorney when the patient becomes involved in litigation.

Before you run to hide behind the law on every question of release of information, there are a few facts you should know about your duty as well as the patient's privilege:

Consent

Both sections of the statutes make it clear that the physician may reveal a patient's secrets if he has the patient's consent or the consent of someone properly and legally representing the patient. Make sure that the patient's consent is an *express* consent—in writing—with the patient's own signature on the writing. A signed consent would carry a lot of weight with the State Medical Society's Grievance Committee or any court in the event of trouble. But, remember, speak only within the limits prescribed by the consent.

Be even more cautious when you rely on consent given by someone on behalf of the patient. You must be sure that you have express consent and, in addition, you must be sure that the person giving the consent is able to consent for the patient. Here are several situations:

- ★ If the patient is a minor child, the parent may give the consent.
- ★ If a minor child for some reason has a guardian, be sure that the person who offers consent for the child has been legally appointed as guardian.
- ★ If the patient has died, reasonable precautions (such as checking with an attorney, a survivor, or a clerk of the county court) should be taken to positively identify the executor or administrator of the patient's estate as one who might validly offer express consent. Unless you have made careful investigation, do not rely on a consent offered by any member of the family of a deceased or incapacitated patient. Such a person may or may not be legally competent to consent.

The Professional Secret

Not everything related to you by a patient is a privileged communication. Only such information as is "necessary to enable him professionally to serve such patient" is within the protection of the law. Many voluntary remarks of the patient are obviously outside the scope of privilege. But here's a word of warning: Some information is privileged even if it does not turn out to be actually useful in diagnosis and treatment. For example, working on the theory that better medical care is possible when

the patient reveals himself fully, many doctors encourage free and easy talk by their patients. Disclosures made under such circumstances would probably qualify as professional secrets because the physician considered such talk necessary to help him serve his patient.

Why Protect the Secret?

The law places a high value on the well-being of the human body just as it shows respect for the home by not requiring a wife to testify against her husband. The law wants the sick to take the steps necessary to restore themselves to health and to have the will to keep themselves well. The law realizes that often the physician cannot care for the patient intelligently unless he is informed of all the facts, including those which the patient might not wish to have made known to his family, friends, or community. Thus, the law lets the patient know that, except for reasons more compelling than his own health, his secrets will be safe with the doctor. With the three exceptions mentioned in paragraph 2, page 34, the law does not even permit its own courts to obtain the patient's secrets from his physician without the patient's consent.

Applies Only to the Physician

Only physicians are exempt from the general rule that courts are entitled to the "truth, the whole truth, and nothing but the truth" from witnesses. This means that nurses, hospital technicians, interns, and others who assist the physician are not exempt from testifying in court with regard to any secrets they may have acquired about the patient. Therefore, you "have your neck way out" if you permit your assistants to obtain any more private information about your patients than they must know in order to do their work efficiently.

Genuine Relationship Required

Privilege does not apply unless there is a genuine physician–patient relationship. For example, information you obtain in an autopsy is not privileged. Neither is information obtained in the course of an examination made for purposes other than the diagnosis and treatment of the patient. If a physician who is also health officer acquires information while making an examination in his capacity as health officer, there is no privilege. The same principle applies when a physician examines an applicant for life insurance. But here is another warning: In all of these situations, you have a legal duty to refrain from willful disclosure as that is explained later.

Strict Interpretation

If courts are to decide issues by applying the law to the facts, the courts must be empowered to demand revelation of the facts. As they rightly should, the courts construe the privilege statutes in the strictest, narrowest sense, leaving as much room as possible for direct inquiry into the facts.

Not long ago, a case before trial court involved a motorist who had received medical treatment for severe cuts suffered in a collision. The physician had already testified that observations as to his patient's sobriety were unnecessary for the treatment administered. Therefore, he was required to testify over objection that he had observed his patient to be drunk.

This ruling by the trial court has not been passed upon by the Wisconsin Supreme Court and is doubtful as a legal precedent. It does illustrate judicial reluctance to permit privilege if a way can be found around it. You should be wary, however, that your freedom of speech at court order does not cause you to forget your duty of silence in other situations.

Willful Betrayal

Before a physician's license may be revoked for violating the patient's privacy, he must be found guilty of "willfully betraying a professional secret." The term "willful betrayal" has not yet been defined by the Wisconsin Supreme Court. It seems unlikely that the court would support a charge of "willful betrayal" unless there had been a showing of some malice on the part of the physician or unless he had fallen clearly or recklessly short of the standards of professional judgment in making his disclosures.

On the other side of the coin are situations in which the physician may even have a legal duty to reveal certain information. Even so, the prudent physician will ask for a signed, written consent before making any kind of revelation. Here are several situations in which the physician may properly disclose matters otherwise to be kept secret:

1. **Claims under the Workmen's Compensation Act.** An employee making a claim for an occupational disease or for an injury suffered in connection with his employment obviously is in no position to require the physician who treated him to withhold his findings from the Industrial Commission. Physicians are not required, however, to disclose confidential information received for the purpose of treatment which is unnecessary to the proper disposition of the claim. It is a practical necessity that the physician attending the injured workman furnish the Commission with information on which to base compensation, and the Commission regards such a physician as the physician of the injured man.
2. **Reportable Diseases.** Any disesase on which the law requires a report to public authorities should be so reported when detected by a physician in the course of treating a patient. Included in this category are venereal diseases; occupational diseases; congenital deformities in newly born infants; and can-

cer, carcinoma, sarcoma, and other malignant growths.

3. **Ethical Considerations.** Practical necessity and ethics may combine to compel a disclosure of information to persons not specifically authorized by statute to receive it. For example, there may be a situation in which a psychiatrist senses possible physical danger to the associates of a patient who is in the process of an insanity determination. The dictates of common sense will tell the psychiatrist to warn the patient's family or even his neighbors. Obviously, such disclosures must be used sparingly and carefully.

Here are some typical situations confronting the average Wisconsin practitioner.

Health Insurance Forms

Many health insurance companies, including Wisconsin Physicians Service–Blue Shield, have anticipated this problem by incorporating a consent for the release of information required to complete the claim in the contract which is delivered to the patient. The physician may feel reasonably confident in completing such forms provided he follows the dictates of his professional judgment and does not transmit more information than is necessary for the proper disposition of the claim.

Public Assistance Forms

Every public assistance recipient is asked to sign a consent for release of information at the time he applies for assistance in obtaining medical or hospital care. Again, the physician should be guided by his good judgment and should proffer only the information he believes necessary to provide payment of a claim.

School Health Examinations

Well-organized school health programs are becoming an accepted part of the educational process. Minimum programs usually involve preschool checkups for kindergarten and first grade youngsters, Wisconsin Interscholastic Athletic Association examinations for students participating in school athletic events, and periodic hearing or sight testing programs. Sometimes these programs go so far as thorough physical examinations for each child at least three times during his elementary and secondary school years. In Wisconsin, these programs are encouraged to utilize the family physician for all such examinations. The private physician is under no obligation to reveal any of his discoveries to school authorities or others. At the same time, he must be aware of his responsibility for the proper physical and psychological adjustment of the child to the educational program. Therefore, he is bound to make recommendations to the school authorities when physical or emotional findings reveal the necessity for shorter class hours, restricted athletic participation, or special attention to emotional factors. On the other hand, the privately practicing physician who has been officially designated as the school physician may quite properly communicate information concerning his findings to the school nurse. Such records and information must be carefully safeguarded within the school system, preferably in locked files. These relationships assume, of course, that the physician will utilize his good judgment and avoid willful betrayal.

Newspapers–Radio–TV–Photographers

The problems in this field sometimes generate more heat than light. In other than "police cases," consent of the patient is essential before release of information. Good judgment and "willful betrayal" are prominent factors in the decision as to violation of the patient's privacy. In several areas, the medical profession has published guides for cooperation between physicians, hospitals, and the press. Local custom must always be considered in dealing with the media of communication.

REFERENCES

1. Oath of Hippocrates.
2. Principles of Medical Ethics, American Medical Association.
3. Wisconsin Statutes, Section 147.20 (1) (d).
4. Wisconsin Statutes, Section 325.21.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: *Section 255.02 (2), Wisconsin Statutes, 1957.*

Warning:

Keep out of child placement

Here is what the physician can do to keep sentiment from overruling caution in adoptions.

WITH nearly 2,000 illegitimate children born in Wisconsin each year, it is only a matter of time before the physician is approached by an unwed mother or a married couple seeking a child.

No warning can be too emphatic: Avoid all entanglement with the emotional and legal webs that surround child placement.

The physician's role in adoptions is clear: Suggest immediately that the parties involved consult with either a licensed child welfare agency or an authorized public agency.

Wisconsin laws, long outstanding for the protection of adoptive children, were further strengthened when the legislature adopted a new Children's Code in 1955. The statutes now prohibit all nonauthorized persons, including physicians and attorneys, from any act as intermediaries in finding children for adoption or making placements. In fact, these statutes specify that no person and "no parent or guardian, except a licensed child welfare agency or public agency authorized to place children for adoption, may place a child in a foster home for adoption without obtaining the written approval of the county court."

Stiff penalties back up the law: Fines up to $500 or imprisonment up to one year in the county jail, or both.

Here is what the physician can and cannot do:

The Physician

SHOULD ALWAYS urge the unwed mother, prospective parents, or others to consult with either a licensed child welfare agency or an authorized public agency. If questions arise, the physician should consult the Division for Children and Youth, 311 State Street, Madison 3, Wisconsin, the state administrative agency charged with such matters.

MUST NOT suggest to any unmarried mother, other natural parent, or legal guardian any particular foster parents for a child he believes available for adoption.

MUST NOT offer to find foster parents for such a child.

MUST NOT offer to find a child for adoption by prospective foster parents.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

Licensed Child Welfare Agencies:

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 2.

Catholic Social Welfare Bureau, 207 East Michigan Ave., Milwaukee 2.

Catholic Welfare Agency, 1209 Hughitt, Superior.

Catholic Welfare Bureau, 3200 South Avenue, La Crosse.

Catholic Welfare Bureau, 25 S. Hancock, Madison 3.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa.

Lutheran Welfare Society of Wisconsin, 3126 West Highland Boulevard, Milwaukee 8.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

Public Agencies:

*Wisconsin Division for Children and Youth, 311 State Street, Madison 3.

*Milwaukee County Child Welfare Division, County Court House, Milwaukee 3.

Licensed Maternity Homes:

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 2224 West Juneau Street, Milwaukee 8.

St. Ann's Maternity Annex (Catholic), 1020 Market Street, La Crosse.

St. Mary's Home (Catholic), 403 South Webster Avenue, Green Bay.

*Summit Hospital, Oconomowoc.

Fees for care in licensed maternity homes vary from $130 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Several institutions provide employment opportunities to cover part of the cost of service rendered. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

MUST NOT place a child with foster parents on a trial or any other basis.

MUST NOT act in any other way as negotiator or intermediary in such matters.

MUST NOT in any other way risk possible violation of the clear terms of the statute.

Professional reputation and ethical standing, as well as a police record, are at stake in the physician's dealings with the unwed mother or prospective parents. Thus, it is absolutely essential that he avoid any conduct which might cause the public to view him as associated with a "black market in babies."

It may help the physician to know that the declared policy of the State of Wisconsin gives paramount concern to the welfare of the child in any adoption procedure. The parents, guardian, and the public interest have secondary consideration. Thus, the Children's Code, by insisting on referral of adoption cases to authorized agencies, offers the physician practical and highly professional recourse in what might otherwise be a dangerous sentimental action.

REFERENCES

1. Wisconsin Statutes, 1955, Section 48.01 (3).
2. Wisconsin Statutes, 1955, Section 48.60.
3. Wisconsin Statutes, 1955, Section 48.62.
4. Wisconsin Statutes, 1955, Section 48.63.
5. Wisconsin Statutes, 1955, Section 48.65.
6. Wisconsin Statutes, 1955, Section 48.76.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service plan.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Occupational Health, A Guide for Medical and Nursing Personnel**—General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
14. **The Income Tax for Wisconsin Physicians**—A brochure, newly revised, containing a review of the state and federal income tax laws as they apply to the physicians of Wisconsin.
15. **The Doctor's Role in Adoptions**—A reprint of three *Wisconsin Medical Journal* articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

the law gets tough with ABORTIONISTS

Do you know how to protect yourself when called to treat an attempted abortion?

EVERY physician should know the Wisconsin law on abortions. It puts the squeeze on the abortion racket, but it lets the honest practitioner know where he stands.

Since July 1, 1956, Wisconsin's Criminal Code has permitted a fine up to $5,000 and imprisonment up to three years for the intentional destruction of the life of any unborn child. If the life destroyed is that of a quick child or of the mother, the imprisonment may be as high as 15 years.

To the law, "unborn child" means a human being from the time of conception until it is born alive. Of course, any pregnant woman who intentionally destroys the life of her unborn child may be fined or imprisoned up to two years.

A therapeutic abortion, however, is exempt from these penalties, but only when three specific conditions have been met:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Important: Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

Criminal abortionists will find the last condition hard on their activities. In the past, abortionists have centered their operations in private establishments or their victims' homes. When caught, they argued their services were necessary to save the mother's life. Now they have the tougher task of arguing that the mother's life was in such immediate danger that there was no time to remove her to a licensed maternity hospital.

The honest practitioner will have no difficulty with the abortion law. But watch out, doctor, when a woman asks you to treat her after an attempted or a completed abortion. Your innocent efforts to aid her may boomerang.

Frequently, an abortionist will merely start the procedure, then advise the woman to consult her own physician for all future care. Her own physician may find it hard to distinguish the criminally induced case from the case with natural causes. Most women would shy from admitting an abortion attempt. If the woman dies, suspicion can easily turn to those near at hand.

One physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion. He said he needed it for his own protection and to help him begin proper treatment. The woman refused the statement and later brought suit against the doctor. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances."

Here are two steps recognized by the highest court in Wisconsin as reasonable precautions before aiding a woman who has attempted or completed an abortion:

1. Insist on the presence of at least one other physician (not an associate) before treatment is given.
2. When no other physician is available, insist on a written statement from the patient, in the presence of witnesses if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in event he later requires it for his own protection.

In every instance, of course, complete, detailed patient records should be maintained.

Sometimes forgotten is the fact that all physicians must immediately report knowledge of any death following an abortion. The report must be made to the sheriff, police officer, or coroner of the county in which the death occurs. Failure to report is a misdemeanor punishable by fine or imprisonment.

Legal counsel for the State Medical Society believes the reporting requirement is intended to apply only to those situations in which the mother dies following an abortion and not to the destruction of a fetus. However, the prudent physician will do well to protect himself by reporting all deaths associated with abortion.

Whenever consulted by a woman who has been treated by an abortionist, the cautious physician will attempt to obtain a complete disclosure by the patient to proper authorities. Frequently this is difficult, if not impossible, to accomplish. Sometimes a woman will attempt to conceal her condition and its cause even until death.

What can the physician do under such circumstances? Primarily his duty is to his patient. He should do the best he can for her up to the time it seems probable that she will die as the result of a criminal abortion or miscarriage. At that stage it would be advisable to call the district attorney to give him a chance to obtain a statement from the patient.

No harm can come from such a procedure. If the patient dies, the physician is bound to report the cause of death. At that time he must either disclose the fact on the death certificate or he must accept the responsibility for being an accessory after the fact by concealing the cause of death.

If the physician does not offer the district attorney a chance to get a statement from the patient and the patient later dies, the physician's reputation may be subject to suspicion. People may wonder what motive he had for failing to give the prosecuting attorney the opportunity to obtain a dying declaration.

REFERENCES

1. Wisconsin Statutes, Section 940.04.
2. Wisconsin Statutes, Section 366.20.
3. State v. Law (1912), 150 Wisconsin 313.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Some birth certificates filed with the State Board of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Committee on Maternal and Child Welfare believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Board of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a possible fine of $100. In addition, it may subject him to a suit for malpractice.

STERILIZATION

The sterilization of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation.

FEE SPLITTING: a medical chameleon

Magazines thrive on it.
Tax men look for it.
Doctors argue over it.
And the law isn't sure.

NOW you see it, now you don't. The chameleon has nothing on fee splitting when it comes to finding it, defining it, or explaining it.

Fee splitting might be nothing more than a simplified method of billing the patient for the services rendered by two or more physicians.

And, depending on how you look at it and how you use it, fee splitting might be "the buying and selling of patients on a commission basis." It may be the incentive for unnecessary surgery. It may be the cover-up for ghost surgery.

Wisconsin statutes have forbidden fee splitting since 1913—calling it "a criminal fraud." The medical profession itself, at all levels and in all specialties, has frowned on it even longer. With each passing year, the speeches, resolutions, and articles of the medical profession get stronger and more vehement against it. Yet in Wisconsin, as elsewhere, no one is really sure what fee splitting means. No one is really positive that all kinds of fee splitting are bad.

Despite the fact that the mere mention of fee splitting may shatter the peace within a hospital's medical staff or send the press reeling with sensationalism, the practicing physician in Wisconsin needs to know the answer to one specific question: "What is legal for me in this state?"

Attorney General's Opinion

There is no clear-cut answer. But here are some guideposts expressed by the Wisconsin attorney general in an official opinion answering questions put before him:

1. Can a surgeon who is not a resident of the city where the hospital is located and who does not hold himself out as a member of the staff of such hospital operate at such hospital and make a charge direct to the hospital under the existing law?

2. Where a country physician engages a surgeon to assist him in an operation at the home of the patient or at the residence of the country physician, can the surgeon make his charge direct to the country physician engaging him or must he make a special contract with the patient?

3. Under these conditions, can the country physician make the contract with the surgeon or must the contract be made directly with the surgeon by the patient?

4. Is a physician who brings a patient to a hospital for an operation or to a surgeon for an operation entitled to a fee for assisting in such operation or for time spent in accompanying the patient to the hospital or place of operation?

5. Can a surgeon charge a regular fee for operations to a physician, including fee for operating room, dressings, anesthetic, etc., irrespective of the ability of the patient to pay, and the physician in charge of the case collect his fee, including such operating fee as he thinks right, the surgeon performing the operation doing the work for and on contract with the physician?

6. If the surgeon or hospital charges a regular fee for operation to physicians, must the same fee be charged to patients who come for operation not accompanied by their physician, or can the surgeon or hospital make a charge suited to the ability of the patient to pay?

The attorney general answered the six questions above by stating as his opinion that the physician's and surgeon's charges should be made *direct* to the patient and that no part of the fee received by the surgeon or hospital should be paid to the physician advising the operation or treatment.

While the attorney general's opinion does not have the same authoritative standing as a decision of the state supreme court, for example, it is important as the official expression of the highest non-judicial legal officer of the state, and both the courts and the legislature have in many cases accorded substantial standing to such opinions.

Hospital Billing Practices

Any hospital which provides radiology, pathology, surgery or other medical service or assistance is required to "render an individual statement" directly to the patient "distinct and separate" from the statement by the physician performing the service (Section 147.225 (3), Wisconsin Statutes.)

This statutory requirement was adopted by the Wisconsin Legislature following the Attorney General's opinion outlined above. The legislative action could have been prompted by the Attorney General's observation that the practice of hospitals in making a charge for medical services, irrespective of the amount paid by it to the physician, is as evil as fee splitting between two physicians or surgeons.

Partnerships and Clinics

Although there is no law on the matter in Wisconsin, and the attorney generals' opinions have not thus far ruled on the point, it is believed that the statute, as phrased, does not forbid the formation of medical partnerships and clinics, or the rendition of a *single* bill for services performed by more than one physician in either organization. It is believed that this is a *permitted exception* to the fee-splitting statute even though two or more physicians in a given partnership or clinic may have rendered services to the same patient in connection with the same general examination or ailment. That is believed to be the *only* exception, however, contained in the Wisconsin statute, and the probable reason for it is that the factual arrangements between two or more physicians in a partnership or clinic are open and generally known instead of being concealed and indeterminate. A secret partnership formed to evade the fee-splitting statute is undoubtedly in violation of that law.

It is apparent that the law specifically prohibits fee splitting. It is equally clear that the lack of judicial interpretation leaves many questions unanswered. The physician's ethics are both strong and specific. Yet, individual circumstances may be the exception. The physician's only safe course is to conduct his practice and his fee arrangements with all the frankness, honesty, and integrity at his command.

REFERENCES

1. Principles of Medical Ethics, American Medical Association.
2. Wis. Statutes, Section 147.225.
3. Wis. O.A.G., Vol. 3, page 218.
4. Wis. O.A.G., Vol. 24, page 580.

WHAT ARE YOUR RIGHTS IN EMERGENCIES?

Question: Suppose a physician in private practice serves as advisor to his local police department. The department calls him, either to the police station or to a private home, where a belligerent alcoholic is creating a disturbance. The physician gives a hypodermic injection to calm him, without the alcoholic's consent, and with or without the nearby relatives' consent. The alcoholic is believed to be endangering himself or those in his environment. Is the physician within his legal rights as a doctor called by the police?

Suppose a similar sequence occurs with a mentally ill patient. The police are following the physician's orders in these circumstances. To protect the patient and others from the violence of the patient, the physician orders restraints applied. Is he within his legal rights as a doctor called in by the police? Assume that no relative is immediately available to take responsibility of the patient.

Answer: Generally, a physician has no authority to administer a hypodermic injection or any other treatment to a patient without the consent of the patient or someone authorized to act on his behalf. If the patient is mentally incapable of speaking for himself because of intoxication, injury, illness, or insanity, consent must be obtained from someone legally authorized to act on behalf of the patient.

An exception is permitted in the case of an emergency, where the patient's life is endangered. Under these circumstances, the law will presume the patient's consent on the theory that, if the patient were rational and able to make his own decision, he would consent to treatment.

A physician going into a private home has no authority to treat the patient without the consent of the patient, or someone authorized to act on his behalf, unless a bona-fide emergency exists in which the patient's life is endangered. Except with regard to persons committed to state institutions, and other situations where specific statutory authority is granted, the police have no authority to authorize a physician to drug a patient against his will solely because he is creating a disturbance or endangering others. The police have power to restrain such an individual by force, if necessary, although force does not include the use of drugs. However, where a patient becomes so violent that it is necessary to restrain him with drugs, the situation is usually one where treatment can be justified because of a bona-fide emergency. **Reference:** "The Physician's Legal Rights in Emergencies," J.A.M.A. (Queries and Minor Notes Section) 161:1518 (Aug. 11) 1956.

how to complete a death certificate

The death of a patient requires at least one legal act by the physician. How he does it can be very important.

MOST death certificates are made and signed by a physician. The reason is obvious—most deaths occur with a physician in attendance. This final legal act by the physician is not a mere routine.

A death certificate is vital in a number of ways. In Wisconsin a human corpse may not be buried or otherwise disposed of before a proper death certificate is made and signed by a competent person. Burial may not take place without a permit for burial or removal. Issuance of the permit depends on a "complete and satisfactory certificate of death."

Here is what the law requires:

1. The certificate shall be made and signed by the physician last in attendance on the deceased.
2. The certificate must specify the time in attendance, the time the physician last saw the deceased alive, and the hour and the day at which death occurred.
3. The physician must state the causes of death in such a way to show the course of disease or sequence of causes resulting in death, and the duration of each.
4. Indefinite and unsatisfactory terms indicating only symptoms of disease or conditions resulting from disease are not acceptable. A certificate containing only such terms will be returned to the physician for correction and definition.
5. The causes of death which may be the result of either disease or violence must be carefully defined. If violence is the cause of death, its nature should be stated, as well as whether it was accidental, suicidal, or homicidal.
6. In case of deaths in hospitals, institutions, or away from home, the physician shall furnish the information required and state where, in his opinion, the disease was contracted.
7. The cause of death and any other facts required must be stated in accordance with the rules and regulations of the State Registrar.

Whoever makes and signs the death certificate must be acquainted with the facts. There may be instances in which the physician last in attendance does not know the cause of death. He may not possess all the information needed to complete a certificate. As a rule, the attending physician does not find it necessary to make a special investigation in order to prepare a certificate. But when a physician is called in to prepare a certificate for a patient he was not attending, he should not insert the information required without first making whatever investigation he feels necessary.

The local registrar may make and sign the certificate if all three of the following conditions are fulfilled:

1. There have been no attending physicians
2. The person desiring to dispose of the body has made request for a burial or removal permit
3. It is impossible to obtain a physician to investigate the cause of death and prepare and execute the certificate "early enough for the purpose."

"Early enough for the purpose" has not been officially interpreted, but it probably means that the local registrar may act in order to prevent an unreasonable delay in funeral ceremonies. If all three conditions are fulfilled, the registrar may make and sign the certificate, utilizing information supplied by relatives of the deceased or other competent lay persons. However, if a physician *may* be obtained he *must* be obtained. Such a physician's services will be paid for by the person seeking disposition of the body. Payment of the physician is reimbursable from the estate of the deceased person as a proper funeral expense.

The coroner may issue a certificate of death:

1. If he has held an inquest on the body
2. Without a formal inquest, if he has investigated a death falling in any of the following specific categories:
   a. Death occurring in a hospital, sanatorium, public or private institution, convalescent home, or the like
   b. Death under unexplained, unusual, or suspicious circumstances
   c. Homicide
   d. Suicide
   e. Death following an abortion
   f. Death due to poisoning, whether homicidal, suicidal, or accidental
   g. Death following accident, whether the injury received was the primary cause of death or not
   h. Death when no physician was in attendance
   i. Death when a physician refuses to sign the death certificate.

REFERENCES

1. Wisconsin Statutes, Section 69.38–69.41.
2. Wisconsin Statutes, Section 69.44 (1).
3. 40 O.A.G. (1951) 476.

W. I. A. A. Benefit Program Experiencing Growth

Offers Five Types of Accident Benefit Plans

SAFEGUARDING the health of all the boys participating in interscholastic athletics is of prime importance to all who are interested in school athletic programs. The Wisconsin Interscholastic Athletic Association endeavors to project that type of thinking into the Benefit Program presently being made available to more than 40,000 high school boys each year. In addition, more than 300,000 boys and girls participate in the Pupil Coverage phase of the Benefit Program and last year approximately $315,000 were paid out in claims by the W.I.A.A. for school injuries of all types.

Because of the receipts realized from the annual W.I.A.A. State High School Basketball Tournament staged in Madison, the Association is able to provide funds for workshops, athletic injuries institutes, coaching clinics, and in addition make available a liberal subsidy for the Benefit Program. The regulatory effect upon all high school athletics in the State of Wisconsin is accepted and respected as are the other services provided by the W.I.A.A

The State Medical Society of Wisconsin functions in an advisory capacity to the W.I.A.A. Matters relating to health and medical regulations are handled through a special medical society committee to the W.I.A.A. Board of Control. This liaison has proved extremely beneficial over the years. As a result, the high school program of health services has improved considerably and the Benefit Program continues to grow.

The Special, or full payment, Plan of the Benefit Program has become extremely popular and at present over one-fourth of the total number enrolled in the Benefit Program are covered by the Special Plan.

Basically, the W.I.A.A. offers five types of accident benefit plans:

1. **Pupil Accident Benefit Plan,** providing indemnity benefits for care of injuries sustained while the pupil is at school or under the direction and supervision of the school. This covers injuries sustained in intramural competition but not those sustained in interscholastic athletic competition.
2. **Individual Accident Benefit Plan,** providing indemnity benefits for students who may be injured while preparing for or participating in interscholastic athletic competition.
3. **Group Athletic Accident Benefit Plan,** providing group rates for interscholastic athletic type coverage to those who are also covered under the Pupil Accident Benefit Plan for other school injuries.
4. **Summer Sports Program,** providing coverage of participants in summer playground, recreation, and sports programs approved by the W.I.A.A. Approved programs are those supported in whole or in part by public taxation, and American Legion baseball.
5. **Special Plan,** covering all pupils for injury in any school-sponsored activity except practice for and competition in interscholastic foot-

ball. This plan will pay for the actual necessary expenses involved in medical-surgical, dental, hospital, or private registered nurse services up to $2,000 as a result of any one accident. Under this plan the physicians bill their usual and customary charges. Under a special provision of the plan, football coverage is available on the same basis but at a special rate.

Under each of the five plans, benefits are not provided for claims resulting from congenital weaknesses or from violations of required safeguards. When safety measures are disregarded, the W.I.A.A. office has attempted to make the necessary correction. The Benefit Program cannot provide indemnity for the following items: boils, skin infections, recurrent dislocations, athlete's foot, broken glasses, orthopedic appliances, orthodontic appliances, ambulance service, prescriptions and injuries resulting from epilepsy, fits, convulsions, diabetes, or any congenital weakness. Athletes with hernias are not permitted to participate in W.I.A.A. sponsored athletic programs.

Through the cooperation of the State Medical Society Advisory Committee, the following medical regulations have been developed and are adhered to in the operation of the Benefit Program:

A. Written notice of the injury on which a claim is to be based must be postmarked to the Association's Executive Office within 21 days after the date of the accident causing the injury. If the report is not postmarked within 21 days but service is rendered by a qualified physician or dentist within this period, the Board of Control may give consideration to any bona fide report received.
B. The Association on the receipt of an injury notice will furnish to the student's school the necessary forms for completing the Benefit request.
C. Benefit requests not completed within sixty days of date of injury will be withdrawn and reconsidered only when approved by the Board of Control. Payment will be authorized only for claims completed and filed in the Association's Executive office within one year from the date of injury.
D. Benefit payment for the loss of life of a covered student is payable to the parent or parents with whom the child is living or in their absence to the estate of the student. All other indemnities of the Program are payable to the person or institution rendering the service.
E. The coverage of a student of a participating school is effective when his Physical and Dental Examination and Parental Permit Card properly executed is postmarked in the mail to the State Association Office. The physical examination must be taken on or after August 1.
NOTE: The above regulation (E) applies to all athletics.
F. A Benefit Request is closed and will not be reopened if the indemnity check for the claim has been presented for payment.
G. First treatment must be given within (21) days to qualify a request for allowances.
H. Payments for consultation and referral services will be authorized only when requested by the original physician and so indicated in his statement.
I. Multiple Injuries. When an accident involves injury to more than one part of a person's body, the indemnity will be that for the major injury plus 50% of the fee for each other injury.
J. The scheduled indemnity is the maximum in each case. The amount actually allowed will not exceed that listed on the itemized statement filed by the physician. Local practice shall determine the fees for treatment.
K. Matters of arbitration will be considered by the Wisconsin Interscholastic Athletic Association's Board of Control and the State Medical Society's Advisory Committee. The attending physician's records and x-ray plates as they pertain to the benefit claim in question shall be available to the arbitration committee.
L. The Board of Control reserves the right to ask for evidence beyond that originally submitted when the Advisor and the Board of Control deem such evidence desirable or necessary to establish the validity of the claim.

Out Patient Services

When the doctor requests the service, a maximum allowance of $8.00 will be authorized for out-patient services such as the use of the operating room, drugs, casts, etc.

Serious Injury Provision

If the expense incurred for necessary medical and dental care exceeds by One Hundred Dollars ($100.00) the Benefit for the injury as provided in the Schedule of Allowances, the Association will pay the amount in excess of the above $100.00. The total amount of the payment by the Association for injuries resulting from one accident shall not exceed $500.00. (The Principal Sum will be in addition in case of death.)

Benefit Request Procedure

1. The faculty member in charge of the School Activity must immediately advise the principal or Benefit Plan Agent, as to time, place and character of injury.
2. The Benefit Plan Agent must fill in the authorization for treatment card and send it with student to physician or dentist of designated preference.
3. The Benefit Plan Agent must advise W.I.A.A., Stevens Point, Wisconsin, within 21 days of accident.
4. Physician or dentist must mail authorization form—prepaid postcard—promptly.
5. If the physician or dentist deems consultation service necessary, same must be requested on Line 6 of his report.
6. If more than 60 days are required to complete a case, extension of time must be requested by the physician or dentist by writing W.I.A.A., Stevens Point, Wisconsin.
7. Physician or dentist must return completed request form to the principal's office for forwarding to the W.I.A.A. The required forms should not be sent by physician, dentist or institution to the W.I.A.A.; all must clear through the principal's office.
8. The Benefit Plan Agent must forward all forms—his own, physician's, dentist's or institution's, as well as all bills in connection with the injury, as soon as completed to the W.I.A.A. These forms must be in within 60 days from date of injury, unless an extension of time has been requested and approved.

NOTE

Benefit claims, except broken teeth and negative x-ray cases, will be valid and compensable only when the athlete remains out of all athletic activity including practice and games for at least the number of days indicated in the schedule below.

	Requiring Reduction	No Reduction
A. Cuts, Medical Attendance and all others		3 days
B. Aspirations		5 days
C. Broken nose, hand, foot, rib or dislocated fingers	12 days	6 days
D. Broken bones (excepting those specified in C)	60 days	30 days
E. Dislocation or separation of joint	30 days	15 days
F. Injuries to knee, involving joint proper and/or internal or external cruciate ligament:		
Moderate—		30 days
Severe—	60 days	30 days
G. Injuries to kidneys—contusion		30 days
Injuries to kidneys—developing hemorrhage, albuminuria or evidence of cellular structure in urine		1 year
H. Rupture of viscus requiring surgery		1 year
I. Skull or intracranial injuries (including all concussions) Minimum	30 days	

(See table of allowances on next page)

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, and alleged father to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a physician or physicians licensed to practice medicine and surgery or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are the results receivable in evidence.

Reference: *Wisconsin Statutes, Sections 52.36 and 325.23.*

	Fractures			Dislocations			
	No Reduction	Closed Reduction	Open Reduction	No Reduction	Closed Reduction	Open Reduction	X-ray Allowance
1. Ankle joint (one or all malleoli)	$ 25.00	$ 60.00	$ 90.00	$ 10.00	$ 35.00	$100.00	$ 5.00
2a. Clavicle	15.00	25.00	50.00				5.00
b. Inner Joint				25.00	25.00	75.00	5.00
c. Lateral Joint				15.00	50.00	75.00	5.00
3. Coccyx	15.00	25.00	50.00				10.00
4. Colles—Radius, Ulna	20.00	50.00	75.00				5.00
5a. Elbow—T. Fracture	35.00	75.00	100.00		35.00		5.00
b. Medial Epicondyle	20.00	35.00	75.00				5.00
c. Lateral Condyle	20.00	35.00	75.00				5.00
d. Radial Head	20.00	35.00	75.00				5.00
6. Femur (shaft)	40.00	100.00	135.00				10.00
7a. Forearm—Radius (shaft only)	20.00	50.00	75.00				5.00
b. Ulna (shaft only)	20.00	50.00	75.00				5.00
c. Radius and Ulna Shaft	30.00	60.00	100.00				5.00
8a. Hip—Intertrochanteric	40.00	100.00	150.00		60.00	75.00	10.00
b. Intracapsular	40.00	100.00	150.00		60.00	75.00	10.00
9. Humerus	35.00	50.00	100.00				5.00
10. Maxilla—Inferior, Superior, or Zygomatic	32.50	70.00	95.00		10.00	75.00	5.00
11. Metatarsal—Single	10.00	20.00	30.00		25.00	40.00	5.00
Each Additional	3.00	5.00	12.50		20.00	30.00	
12. Nose	10.00	25.00	75.00				5.00
13. Patella	20.00	25.00	110.00				5.00
(semilunar cartilage)				15.00	25.00	100.00	5.00
14. Pelvis	30.00	60.00	100.00		60.00	150.00	10.00
15. Rib (one or more)	15.00	15.00					10.00
16. Scapula	15.00	50.00	100.00				10.00
Shoulder					25.00	75.00	10.00
17. Skull and/or Cerebral Hemorrhage		50.00	100.00				10.00
Skull—No Cerebral Damage	25.00						
18. Spine (vertebral body compression, one or more)	30.00	75.00	150.00	25.00	75.00	150.00	10.00
							entire 20.00
19. Sternum	10.00	25.00	50.00				5.00
20. Tarsal Os Calcis	25.00	50.00	60.00				
21. Tarsal (excluding os calcis)	20.00	50.00	75.00		35.00	75.00	5.00
22. Tibia (involving knee joint)	30.00	75.00	110.00				5.00
23. Tibia or Fibula Shaft or Both	25.00	60.00	75.00				5.00
24a. Toe—Great	10.00	15.00	15.00				
b. Other Toe	5.00	10.00	10.00		5.00	10.00	5.00
c. Each Additional	3.00	5.00	5.00		5.00	10.00	
25. Transverse Process	10.00	10.00					10.00
26a. Wrist and Hand—Carpal	25.00	25.00			35.00	75.00	5.00
b. Metacarpal (single)	10.00	20.00	25.00		15.00	25.00	5.00
c. (each additional)	3.00	5.00	10.00		10.00	10.00	
d. Finger	5.00	15.00	25.00		5.00	15.00	5.00
e. (each additional)	3.00	5.00	10.00		5.00	10.00	

"Recent Advances in Therapeutics," Course at UW

A one-day postgraduate course, "Recent Advances in Therapeutics," will be held Thursday, February 19, at the Wisconsin Center Building, Madison, by the University of Wisconsin Medical School. There will be a $5.00 registration fee plus $10.00 course fee.

This course will cover four areas of therapy which are either new developments or about which there have been frequent questions. Both lecture presentations and the discussions will be aimed at the particular level for the benefit of the physician in practice.

Further information may be obtained from Robert C. Parkin, M.D., Coordinator of Graduate Medical Education, University of Wisconsin Medical School, 418 N. Randall Avenue, Madison 6, Wisconsin.

WHAT TO DO WHEN MALPRACTICE THREATENS

Should you fight or settle? Here's a helpful formula for handling a delicate situation

LET'S face it—there is no guarantee against a malpractice suit.

Sooner or later, you'll almost certainly be faced with a claim, justified or not. How you react may save your reputation, protect your pocketbook, and stave off a flood of nuisance suits.

Each case is different, but here are some fundamentals that every doctor should know:

1. Keep your eyes open

Watch your patient's emotional and psychological reactions. Be alert to dissatisfaction, grumbling, and uneasiness of the patient or his family. Keep an ear cocked for rumors from outside. Early recognition may give you time to repair strained relations.

2. Don't panic—just listen

Your real test will come when the complaint or accusation is made. There's a strong temptation to defend yourself, argue, alibi, explain, or even retaliate. If you remember nothing else, remember this: Don't do it. Just listen carefully and patiently and be thankful you're getting that much advance notice.

3. Speak with extreme caution

Anything you say may be held against you. Not long ago a patient threatened a Wisconsin physician with malpractice when her "sprained knee" turned into a long-term disability. Confronted in his office by the patient, the doctor did a quick recheck of the situation and replied, in effect, "You're right. If I'd taken a couple of follow-up x-rays three months ago, we would have caught it." This admission was "manna from heaven" to the patient. Whether or not the doctor's treatment had been good medical practice, his impromptu remark forfeited any defense he might have had. The case was settled out of court.

The case of the sprained knee is a good example of what lawyers call "the doctrine of *res ipsa loquitur*," that is, the thing speaks for itself. Technically, *res ipsa loquitur* is held to apply whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

In the field of malpractice, the doctrine of *res ipsa loquitur* has been applied chiefly to cases which involve slipping instruments; sponges left in the tissues; burns from heating modalities; roentgen radiation injuries, generally limited to cases in which the roentgen ray is being used in diagnosis; infection through the use of an unsterilized needle or instrument; or injury to a portion of an anesthetized patient's body outside the field of treatment or operation.

Similarly, a single careless statement or admission might create liability for damages where no liability exists. What is more, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony to prove the alleged malpractice. The doctrine of *res ipsa loquitur* infers negligence on the part of the defendant. Its application forces the defendant to explain away the inference if he can.

4. Be quick to notify your insurance carrier

As soon as you suspect a malpractice suit in the making, notify your malpractice insurance carrier immediately and get private legal counsel. Don't wait. Any delay may be disastrous to the preparation of a defense. Adequate defense in the unjust malpractice case is a difficult task. No doubt poor defense has lost many a case. Physicians with little or no knowledge of the law are obviously out of place in attempting to defend themselves. Lawyers with little or no medical knowledge or experience in malpractice cases are not a good bet. In the face of a suit, you will be wise to find the best available expert advice.

5. Be slow to compromise

Don't be too quick to settle. Many doctors operate on the theory that a small settlement will be less

expensive than the cost, publicity, loss of time, and mental and emotional strain involved in the defense. Experience shows that unjust and absurd malpractice claims double and triple in areas where doctors are found to be a "soft touch." The increased number of malpractice claims and the higher insurance rates are a direct result of the "settle-it-quick" attitude on the part of many doctors. For your sake and that of your colleagues, you should make a determined opposition to any unjustified claims.

6. Collect your defenses

At the slightest possibility of a claim, begin to pull together your records, reports, and other evidence which might be required for your defense. At this point, every shred of recorded evidence becomes mighty important. But in no case should you alter your existing records in any way.

7. Settle a meritorious claim out of court

The doctor who is actually guilty of malpractice is not likely and probably should not be allowed to go free of penalty. Let your conscience, not alone your pride, be your guide. Meritorious claims should be settled out of court—preferably before a suit has been filed. But never settle without having competent legal advice.

PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Box 1109, Madison 1, Wisconsin.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11 with one inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wis. Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

Reprints: An order slip for reprints with a table covering cost will be sent with the page proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

How Long Should You Keep Case Records and X-rays?

Records are your property, but go slow when discarding them

PAPER work has many physicians on the verge of hysteria. There's more of it. It costs more to produce. It takes more office personnel. It takes more time. And what's more, the records of it live to haunt you.

Here's what's happening around Wisconsin:

★ A clinic in operation for 20 years has a large room filled to overflowing with bulky case records. Expansion of storage is expensive. But conversion to newer, less space-consuming records would cost over $2,000.

★ Another two-man clinic started three years ago is grumbling over bulky, inconvenient records and the accumulation of paper and is already pushing into valuable examining and laboratory room space.

★ One physician was literally forced out of house and home when his wife objected to records from the home-attached office spilling over into the living room.

Can a systematic destruction program solve this problem? How long should you keep your professional case records and x-rays?

With a couple of limitations, the professional records of physicians are generally considered the property of the physician who makes them. Of course, he must be able to assure the patients that the records are being kept in confidence; and ethical considerations require that he make them available to a succeeding physician upon the request of the patient.

Otherwise, you have a clear property right to your professional records and x-rays. Thus, you have the legal right to destroy them, except when prohibited by statute.

But before you toss the whole "kit and caboodle" into a bonfire, here are a half dozen good rules to remember:

1. Keep narcotic and other prescriptions at least two years. If you don't, you face severe penalty—even revocation of your narcotic license. The State Board of Health prescribes the records you should keep on narcotics. Follow its advice, and you will meet the requirements of both the Wisconsin and federal statutes.
2. Retain all other patient records as long as they have any conceivable value, either to the physician or to the patient—and in no event for less than six years. This, you say, could be forever. That may or may not be. Here are some examples:

★ Premature destruction of professional records and x-rays could obviously be a disservice to the patient and result in great harm in many situations.

★ A patient who has not used your services for many years might return specifically because you had once cared for him. Even if a patient seems to be leaving the reasonable vicinity of your service, you may be called upon to provide a succeeding physician with his records.

★ Your records should be retained for that period of time during which the record of treatment and diagnosis may be needed by the patient in the prosecution or defense of

WHAT WOULD YOU DO?

SITUATION: Mrs. John Jones was diagnosed as cancer, malignant. Prognosis: Poor. She left Wisconsin to live with relatives in Oregon. Six months later she wrote her previous physician, Dr. John Doe, asking that he send her complete medical record to her new doctor in Portland. Doctor Doe protested, saying her voluminous record of care and treatment for the previous five years, including x-rays, would be costly to reproduce.

COMMENT: Doctor Doe has an obligation to make his records available to a succeeding physician at Mrs. Jones' request. The force behind this is mainly ethical, but the failure to provide adequate records with reasonable promptness for the use of the succeeding physician may jeopardize Mrs. Jones' health and thus open a possibility of a malpractice claim where none existed before. On the other hand, Doctor Doe is not required to send his only copies of these records and might reasonably request Mrs. Jones to pay the cost of reproduction for the necessary copies. If there is a question of malpractice involved, consult your attorney, insurance company, or the State Society office.

a legal action or in the establishment of some legal right. Records are of particular importance to the patient in establishing a service-connected disability claim against the Veterans Administration, in determining the mental capacity in a will contest, in evaluating personal injury in an automobile accident, and in determining the extent of disability resulting from an industrial accident in a claim under the Workmen's Compensation Act.

★ Records are vital for defense in malpractice claims against the attending physician and the hospital, if it is involved. Wisconsin statutes require that one alleging a malpractice must assert that claim by institution of legal action within three years of the occurrence of the alleged event. This applies even to those who may be incapacitated by reason of infancy or insanity. Even when no suit has been filed within three years, the patient may still question the value or quality of the professional service as a defense to an action by the physician to collect fees. A collection suit will not then revive the patient's right to damages, but the lapse of that right will not keep him from arguing that the services were so far below standard as to be noncompensable. Such a collection action must be commenced within six years. Thus, if you think it may be necessary to resort to legal action in the collection of your fee, it would be smart to keep your professional records for at least that six-year period.

3. Keep all pertinent records indefinitely as long as there is a known or threatened legal complication such as a malpractice or collection suit.
4. When a suit is actually brought against you by a patient (or someone acting for him), you must preserve all patient records, including x-rays, laboratory reports, and correspondence, until your attorney advises that in his judgment the time is past within which other litigation that might grow out of the first suit could be brought. This may be some time after the litigation has been concluded.
5. If you should bring a suit against a patient, the same time periods must be carefully observed, leaving the final determination to the judgment of an attorney.
6. Records should be preserved even longer than usual if the case is affected by mental incapacity, infancy, or imprisonment of the patient. Rely on your attorney's advice.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

The sale of contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used, is prohibited by Section 151.15 of the Wisconsin Statutes to all persons other than a physician or pharmacist duly licensed in this state. In no event may such article, drug, or preparation be sold to any unmarried person.

Prohibited also is the advertising or displaying of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of not less than one hundred dollars ($100.00), or imprisonment in a county jail for not to exceed six months.

THE LEGAL STATUS OF A DOCTOR WITHOUT A PERMANENT LICENSE

THE preceptee and the intern are not licensed to practice medicine in Wisconsin. What duties may they legally perform? The resident has a license. Is he limited in any way? The doctor with a temporary educational certificate which he can hold for no more than three years—what are his limitations?

These fine lines of licensure have been the cause of concern to many physicians. Here is a summary of the legal standing of the physician who does not have a permanent license to practice in Wisconsin.

PRECEPTEES

The term "preceptee" or "extern" is professionally understood to refer to advanced medical students who have not as yet completed their college course in medicine. A preceptee is one who has not yet reached the intern stage. He is not licensed to practice medicine. Nevertheless, a preceptee performs certain assisting and observing functions, either during a vacation period or during his fourth year of medical study, under the supervision of a licensed physician. Preceptees participate in this portion of their training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

A preceptee is generally an assistant of a physician. The duties delegated to a preceptee by a physician are usually very much limited, relating only to observation. Thus, a situation would seldom arise in which an act of a preceptee might cause injury. A physician presumably has the duty to see to it that the preceptee is delegated no duty which would call for discretion or judgment on his part. However, a negligent act on the part of a preceptee in the treatment of a patient is a responsibility of the physician under whom he is working.

INTERNS

An "intern" is generally understood to apply to one who is engaged in a twelve months' period of advanced study and apprenticeship immediately subsequent to the completion of his college course and prior to the granting of his license. Internship is a prerequisite for the granting of a license to practice medicine and surgery in Wisconsin. After one year of internship, unless his medical school requires a longer period of internship as a condition of graduation, the intern must be licensed and have the legal status of a practicing physician.

An intern does not have the full legal status of a licensed practitioner. He does have certain functions of a medical nature which he is permitted to perform. The Wisconsin Supreme Court has admitted that interns are not subject to the Medical Practice Act because the Wisconsin statutes require an internship as a part of one's medical education prior to licensure. The court summarized the legal status of an intern in Wisconsin as follows:

> "This is a legal sanction of the performance of such duties on the part of interns as are usually and ordinarily performed by them. The performance of such duties does not constitute the practice of medicine, or a representation that the intern is authorized to practice medicine."

Interns are not within the provisions of the so-called "medical privilege statute."

When it comes to responsibility for negligence of interns while performing their customary duties, it is clear that they have a personal responsibility. The responsibility for their acts, however, may extend to the physicians under whom they are working, or to the hospital employing them. The law generally holds the intern to be an employee or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents, within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the Workmen's Compensation Act, which extends employee protection to interns injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of interns in the performance of duties which are customarily performed by them. Exemption, however, has been made in the case of charitable hospitals which are protected by law for the acts of their employees or servants. However, where the intern is acting under the direct supervision of a physician during the course of an operation, the hospital is absolved from responsibility and his acts become those of the physician who has charge of the work.

HOLDERS OF TEMPORARY EDUCATIONAL CERTIFICATES

The 1953 legislature provided for the granting of "temporary educational certificates" to certain physicians who wish to take advantage of postgraduate education in Wisconsin but who are otherwise unable to meet the licensure requirements of the state. Such a certificate entitles the physician to take post-

graduate educational training in an accredited teaching hospital. These certificates are normally issued for only one year, but may be renewed for an additional two years. Any person holding a temporary educational certificate must act under the direction of a person licensed to practice medicine and surgery in Wisconsin.

Under such direction, the holder of a temporary educational certificate has the right to prescribe drugs other than narcotics and to sign any certificates, reports, or other papers for the use of public authorities which are expected of a regularly licensed physician. Likewise, under supervision he may perform those services required for the completion of his postgraduate educational training.

These certificate holders must confine their training and practice to the hospital in which they are taking postgraduate education. Neither they nor the hospital may receive any fees or other income for their services from any patients treated by them during the course of training.

RESIDENTS

A "resident" is usually understood to mean a person engaged in postgraduate medical education beyond the period of internship. In any event, a resident is required to hold a regular, permanent license to practice medicine. He is as fully responsible for his acts or omissions as any other licensed practitioner.

TEMPORARY LICENSES

The legislature has recognized the substantial period of time that may elapse between the filing of an application for a license to practice medicine in Wisconsin and the granting of such a license. It also has taken note that the need for medical services in a given community can be critical.

The legislature has authorized The Board of Medical Examiners to grant, without examination, temporary licenses to practice medicine. The authorization is subject to these safeguards, however:

1. The temporary licensee must have applied for a permanent license and must have satisfied the board that he possesses all educational and other prerequisites for permanent licensure—save only the examination.
2. Two officers of the board must have determined that an emergency need exists for medical personnel in the community where the temporary licensee desires in practice.
3. The temporary license expires 30 days following the next examination for permanent license conducted by the board.
4. A temporary license will be granted only once to the same person.

A temporary license grants to its holder all of the privileges and responsibilities of a permanent license while it is in force and effect.

Licensing of Foreign-Trained Physicians

THE 1957 Legislature made provision for the permanent licensing of certain foreign-trained physicians who come to Wisconsin.

The legislation was developed to permit Wisconsin to accept certain highly qualified individuals trained in foreign medical schools who might otherwise be unable to practice in the state. It is intended basically as an interim device to the creation by the American Medical Association and other national licensing agencies of a national and international screening system for foreign-trained medical school graduates.

Under the new law, Section 147.15 (1m) of the Statutes, certain foreign-trained applicants may be granted a permanent license provided they meet certain educational prerequisites.

Such applicants must have professional qualifications through recognized postgraduate work done in this country or through professional experience or both which give them premedical training substantially equivalent to that offered in the premedical course at the University of Wisconsin or professional training substantially equivalent to that of the University of Wisconsin or both. When the State Board of Medical Examiners is satisfied as to an applicant's equivalent premedical and medical training, the license may be granted. In the course of ascertaining the individual's training, the dean of any medical school approved and recognized by the Board must examine the premedical and medical qualifications of the applicant and state that the applicant meets the present standards for graduates of the professional school which he heads. No more than 25 licenses a year can be issued under the Statute and it expires on July 1, 1961.

YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes

1. By January 15, 1959, you must pay the final installment of the estimated federal tax on your 1958 income. This may necessitate an amended declaration by that date if you find that you underestimated 1958 income. A final income tax return for 1958, filed before January 31, 1959, will be treated as the equivalent of an amended declaration as of January 15. Penalties are assessed for certain underestimating of taxes. These penalties and their legal avoidance are discussed in Section 5 below.
2. By January 31, you must:
   (1) File the employer's final return of income taxes withheld in 1958 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1958.
   (3) File fourth quarterly return for 1958 of income and social security tax withheld on wages paid employees on Form 941 if:
      (a) The entire tax was not paid by timely depositary receipts for all three months of the preceding quarter; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1958.
   (4) Pay income and social security taxes withheld on 1958 wages of employees if:
      (a) More than $100 was withheld in December, 1958, and not paid to government depositary earlier in January, 1959; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1958.
3. Miscellaneous:
   (1) If the total of income and social security tax withheld on employees' wages exceeds $100 a month in each of the three months of the preceding calendar quarter, and payments were made to a government depositary previous to the fifteenth of the next month, the quarterly return on Form 941 should be filed on or before the tenth of February, May, August, and November, as the case may be.
   (2) If instructions contained in paragraphs (3) and (4) of Section 2 preceding are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31, 1959, for the respective preceding calendar quarters.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid to a government depositary by the fifteenth of the month immediately following or may accompany the quarterly return if the latter is filed by the end of the month following such calendar quarter.
4. File your Wisconsin and federal partnership and personal income tax returns as early in 1959 as possible, but no later than April 15. State returns should be filed with the assessor of incomes in the district in which you live, Federal returns with the Director of Internal Revenue, Milwaukee.
5. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1959 income must be shown on a federal declaration form which has to be filed, together with the estimated tax due, by April 15, 1959. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1959. As to the final payment or amendment of declaration due in January, 1960, follow the alternative procedure described in Section 1 above.

Excluding cases of willful understatement, interest penalties are provided for underestimating and thus underpaying taxes on declaration of estimated income, to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, as shown on the filed return. A penalty of 6 per cent computed on the amount of the underpayment from the due date of a particular installment is added to the tax. The penalty can be legally avoided in either of two ways. The first is to base the estimated tax upon the previous year's income at 1959 tax rates and exemptions in force at the time a particular installment is being paid, or to base quarterly payments on the previous year's tax, whichever is the lesser. The second is to follow the so-called "90 per cent rule." This is a rather complicated formula, and each physician who cares to follow it should consult his attorney or tax accountant.

Annual Registration in Wisconsin; Annual Narcotics Registration

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners, Room 1140, State Office Building, 1 West Wilson Street, Madison 3, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.
2. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1959. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. Notify the Director of Internal Revenue, Milwaukee, Wisconsin, to insure the legality of your narcotics license. Penalties are imposed for failure to do this.

Remember to:

1. Make prompt report to the State Board of Health, State Office Building, 1 West Wilson Street, Madison 3, of cancer cases, communicable diseases and others.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.
5. Report *immediately* the following deaths, as required by Section 966.20, statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate.

Federal and Wisconsin Unemployment Compensation Liability.

See in this connection the text of the box on page 12 of this issue.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

* As amended by the 1958 House of Delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society,

life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its mem-

bers as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between an-

nual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Council on Scientific Work.
- A Council on Medical Service.
- A Committee on Public Policy.
- A Committee on Grievances.
- A Committee on Medical Education and Hospitals.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Hospital Relations.
- A Committee on Cancer.

Unless otherwise provided in these By-laws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Council on Scientific Work shall consist of five *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the Wisconsin Medical Journal. Each appointed member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service shall consist of nine members appointed by the president of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Council on Medical Service shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

The Council shall direct the program of the Society in the field of public health education, and in such manner as is found suitable, shall seek to further the health of those employed in Wisconsin industry, as well as to promote the health and safety of those engaged in rural Wisconsin.

SEC. 4. The Committee on Public Policy shall consist of seven members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

The Committee on Hospital Relations of the State Medical Society of Wisconsin is specifically charged with the responsibility of receiving and considering

all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen between a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its findings to that effect shall be transmitted to the Council of the State Medical Society of Wisconsin with its findings and recommendations in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

SEC. 9. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 10. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships:* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine. shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may pro-

vide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The term of office shall be pursuant to the constitution and by-laws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and by-laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and ex-

penditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII
SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1959–June 30, 1959

STATE DEPARTMENT OF PUBLIC INSTRUCTION, BUREAU FOR HANDICAPPED CHILDREN

CRIPPLED CHILDREN DIVISION, MADISON 3, WISCONSIN

LOCATION	*DATE*	*LOCATION*	*DATE*
Manitowoc	February 18 and 19	Marinette	April 29
Ashland	February 25 and 26	Fond du Lac	May 13
Kenosha	March 11 and 12	Appleton	May 14 and 15
Racine	March 18 and 19	Superior	May 22
Wausau	April 2	Chippewa Falls	May 27 and 28
Eau Claire	April 9 and 10	Rhinelander	June 3 and 4
La Crosse	April 14 and 15	Darlington	June 10
Sheboygan	April 22 and 23	Lancaster	June 11

FOR: The clinics conducted by the Crippled Children Division of the Bureau of Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinics so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, Wisconsin.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

. . . . THE PRESIDENT'S PAGE . . . .

Two Sides of a Mountain

IT WAS the night of Tishah Beah, the day that the Jews lamented and commemorated the destruction of the Second Temple in Jerusalem in 70 A.D. by Roman legions under command of Titus, when a bomb shattered the Knesset Israel Synagogue in Buenos Aires in 1947. Head Rabbi Schlessinger wandering amidst the rubble cried out, "What have I done? Why was the house of the Lord profaned?" A black robed figure stepped forward and answered, "prejudice, hate, and ignorance have struck." His hand outstretched, Father Cucchetti added, "I come to offer you my sympathy." Replied the Rabbi, "I shall never forget your kindness."

Eight years later in 1955, during Dictator Peron's church burning war on Catholicism, the same bomb-hurling gangs switched from Jews to Catholics, beat up friars (one was killed) and tried to catch anti-Peronista Father Cucchetti. When the Catholic hierarchy supported Peron, Father Cucchetti blasted his superiors and was relieved of his parish. When Peron turned against the Church, the priest shed his cassock, and hiding out, organized anti-Peron resistance. To his hiding place came a friendly visitor—Rabbi Schlessinger.

In July 1956, with Peron booted out of Argentina, Father Cucchetti went to Italy, talked over his idea for a Christian-Jewish brotherhood movement with Vatican officials. Next he visited Israel. Later, in Buenos Aires he launched his first trial balloon, a message in La Prensa: "Judaism and Christianity are two sides of one mountain at the summit of which is the idea of the Messiah."

Conservative Catholics frowned; rank and file Protestants, led by Methodist Minister Adam Sosa who had joined the Rabbi and the Priest, kept silent. Wealthy Jews retreated. However, "the three musketeers," as supporters tagged them, did not lose zeal.

This friendship of Priest, Rabbi and Minister established in Latin America the first interfaith union called Movimiento de Confraternidad Judea-Christian. The program of the Confraternidad is to be spread through radio, press, lectures, and books. The objectives are: (1) to mold a collective soul through the union and understanding of all believers in religion (God), (2) to form a common front against souless forces which destroy the dignity of man, and (3) to promote the spiritual significance of democracy.

Father Cucchetti says with the words of a dedicated priest (the theme that I shall try to interpret, cultivate, and disseminate during my term of office): "The days of preaching about what divides us are over. Now is the time to preach about what unites us. The sides of the mountain always lead to the top."

Let us then, the members of the medical profession in Wisconsin, solemnly dedicate ourselves to the task of climbing back to the top where, with God's help, we shall stay. Without the help of one another, working hand in hand and shoulder to shoulder, whether we are from Mauston, Menasha, Madison, Milwaukee, or Marinette, we shall surely be pulled down into an abyss from which there may be no return.

William B. Weldenhaus, M.D.

Editorials

A Unique Edition

The Blue Book January edition of THE WISCONSIN MEDICAL JOURNAL is a unique institution among the medical journals of the United States. Begun in 1924 these annual editions have been devoted largely to medico-legal matters and a variety of information of concern to the physician in his relationship to governmental agencies.

This Blue Book is no exception. Certainly of primer personal interest to every physician is an article on possible tax savings through the use of a trust device. Protection against malpractice, the doctor's role in adoptions, workmen's compensation problems and a host of everyday situations with legal implications are described in detail. The pages on important "deadlines" are worth a second look. In just a few minutes, a member may review the Constitution and Bylaws and committee structure of his state medical organization—a good thing to do from time to time.

Last year, in the 1958 Blue Book, the Society presented a notable compilation of medical "consent" forms of all types. They are an invaluable reference.

Each of these issues is an outstanding legal service to members of the Society. Be sure to keep and review the Blue Book issues.

Photographers Wanted

An invitation has been extended by the Society's Foundation for physicians to participate in a most unusual and significant photography exhibit.

It is unusual because it is the first of its kind to be sponsored by the Society exclusively for and about physicians. It is significant because it is an important means of recording today's people and events for the future. This is a project fostered by the Section on Medical History. Out of it will come a collection of photographs showing physicians at work, at play, in public service, in research and teaching and in activities which are now history in themselves.

Time and events move along so rapidly these days that one is prone to forget the importance of documenting the seemingly insignificant efforts of individuals. It is these efforts, however, which form the backbone of constructive contributions to better health and better living that have been made by the medical profession over the years. They must be documented now or they may be lost forever.

Already many physicians have indicated that they will exhibit photographs for this show at the Annual Meeting. This is an appeal to physician photographers and those interested in medical history to prepare one or more presentations of photographs. They may show physicians in current situations or they may be old-time pictures resurrected from albums and heirlooms. Most important—they must show physicians or places and activities related to medicine.

If you are interested write Photography Exhibit, State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

The New Year

The twelve months of 1959 seem a long road, and a bumpy one, in the face of a possibly stormy legislative session, major public relations repairs, and a quackery blowout or two. On the brighter side, however, is a happy development right within the medical family. It is the fifth year of the Charitable, Educational and Scientific Foundation of the State Medical Society.

The lead article of this issue of THE WISCONSIN MEDICAL JOURNAL reports the facts in detail, but so much of the human element remains untold.

How does one express the relief and the new hope exhibited by a medical student whose career faced ruin until the SMS Foundation student loan fund came to his aid?

No words will explain the tears of humble gratitude tumbling down the cheeks of an aged and nearly sightless physician as he accepted a Foundation gift to help him keep body and soul together for another month.

How can words interpret the understanding that will come to the public as the Medical Museum explains the role of medicine in human affairs?

The months and years ahead may seem rough at times, but a generous gift in timely fashion to the Foundation will brighten the future not only of the recipient but also of the giver.

The "Home" of the State Medical Society on the south shore of Lake Monona houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, and Council room. Nearly 200 committee and other meetings are held here annually.

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Fischer, W. A.
Moore, R. M.

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Wallestad, P. W.

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Rohde, E. P.

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Barcome, D. F.

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Limberg, P. W.
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Pelant, K. F.
Seidl, J. A.

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Troup, R. L.
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Kuglitsch, E. F.

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Algiers, J. L.
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Hoffmann, W. C. P.
Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
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Quandt, V. V.
Sachse, F. W.

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Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Pleyte, A. A.
Sandell, S. T.

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Sahs, M. H.
Stang, H. M.
Wyant, M. E.

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Murray, J. F.
Strauch, C. B.

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Hilbert:
Winkler, R. J.

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Balder, R. E., Jr.
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Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, J. H.
Knudson, R. A.
Schulz, N. H.
Schutz, W. J.

Hortonville:
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Towne, W. H.
Van Gilder, J. H

Hudson:
Anderson, M. G
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Newton, J. E.

Hurley:
Martinetti, D. J

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Farnsworth, R. W.
Fitzgerald, G. P.
Fitzgerald, R. E.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gutmann, G. E.
Hartlaub, E. S.
Johnson, W. L.
Klein, T. W.
Koch, V. W.
Llewellyn, M. B.
McGuire, W. H.
McNichols, E. F.
McSweeny, A. J.
Metcalf, G. S.
Nash, C. B.
Neeno, Katsumi
Nuzum, T. O.
Odland, P. K.
Otterholt, E. R.
Overton, R. S.
Pember, A. H.
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Schroder, John R.
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Sholl, P. R.
Smith, D. A.
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Busse, A. A.
Quandt, C. E.
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Robinson, A. H.

Johnson Creek:
Wendt, F. A.

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Ferguson, E. C.
Heath, H. J.

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Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.

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Andre, E. F.
Armstrong, G. F.
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Creswell, C. M.
Davin, C. C.
Davis, D. W.
DeFazio, S. F.
Duncan, J. T., Jr.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
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Kappus, H. C.
Kent, L. T.
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Mayfield, A. L.
Meeter, U. L.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
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Powell, R. A.
Randall, A. J.
Rattan, W. C.
Rauch, A. M.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Rufflo, A. F.
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Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Stewart, W. C.
Swift, W. J.
Turner, Lewis, III
Ulrich, C. F.
Weber, G. R.
Welsch, R. G.
Williams, F. C., Jr.
Wood, Fredrick, Jr.

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Edwards, R. G.

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Lanier, Patricia A.
Nesemann, R. M.
Wits, E. W.

Kiel:
Nauth, D. F.
Theiler, A. C.
Twohig, G. J.

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Curtin, D. W.
Gage, Ralph S.

Kohler:
Gascoigne, C. C.
Rowe, D. M.

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Bach, A. C.
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cejpek, K. O.
Cook, A. A.

Daley, D. M.
Dalton, R. M.
Dietz, P. C.
Doyle, D. F.
Durst, J. B.
Egan, G. J., Jr.
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Ernst, F. W.
Fisher, A. L.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
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Gatterdam, P. C.
Getz, Kaare
Gilbert, R. L.
Gorenstein, L. M.
Gundersen, A. H.
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Gundersen, T. E.
Harman, J. C.
Hickey, A. W.
Himmelsbach, W. A.
Hulick, P. V.
Jaeck, James L.
Jensen, Alfhild
Jones, W. J.
Joseph, L. G.
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MacEwen, A. R.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
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McNamara, T. B.
Midelfort, C. F.
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O'Meara, M. T.
Pauly, James P.
Perry, E. L.
Phillips, P. W.
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Ramlow, R. W.
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Richter, J. R.
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Schneeberger, E. J.
Schuldes, R. E.
Sevenants, J. J.
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Skemp, F. C.
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Smith, D. S.
Swanljung, H. A.
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Uhrich, G. I.
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Lake Geneva:

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Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.

Lake Mills:

Eck, G. E.
Liebenow, R. R.
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Schoenecker, E. A.
Turcott, R. A

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Jackson, R. D.

Land O'Lakes:

Eickhoff, E. C.

Laona:

Castaldo, E. F.
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Rose, J. F.

Little Chute:

Van Lieshout, F. X.

Lodi:

Groves, R. J.
Irwin, W. G.

Loyal:

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Allin, R. N.
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Geppert, T. V.
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Moore, J. N.
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Orth, O. S.
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Piper, P. G.
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Price, D. O.
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Richtsmeier, A. J
Ris, Hania W.
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Roemer, E. P.
Rogers, S. C.
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Rotter, Royal
Rounds, W. M.
Rowe, G. G.
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Salick, J. A.
Samp, R. J.
Satter, E. J.
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Schilling, R. F.
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Schmitz, R. C.

Schneiders, E. F.
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Schroeder, J. M.
Schubert, C. K.
Schultz, A. E.
Schuster, D. S.
Schwittay, Addle M.
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Shapiro, H. H.
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Shumate, J. K.
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Sprague, L. V.
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Turgeson, J. H.
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Urben, W. J.
Van Duser, A. L.
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Vanstane, V. R.
Vermund, Halvor
Vingom, C. O.
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Vogt, G. H.
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Washburne, Annette C.
Waskow, W. L.
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Weatherhogg, C. R.
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Williams, D. L.
Winston, Margaret C.
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Wixson, R. C.
Wolberg, W. H.
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Manawa:

Irvine, R. K.

Manitowoc:

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Banker, R. J.
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Bonner, N. A.
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Donohue, W. E.
Erdmann, N. C.
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Hoffman, G. M.
Lynch, J. D.
MacLean, C. R.
Perry, T. K.
Pick, D. M.
Puestow, R. C.
Radl, C. J.
Randolph, R. C.
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Rau, G. A.
Rauch, W. A.
Rees, T. H.
Sargeant, C. D.
Schaefer, H. E.
Scherping, W. H.
Schochet, S. S.
Shaw, Jesse W.
Simon, G. M.
Smejkal, W. F.
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Teitgen, T. A.
Thorpe, R. F.
Wall, C. E.
Yost, R. G.

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Kampine, C. E.

Maribel:

May, J. H.

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Duer, G. R.
Koepp, C. E.
McCanna, P. R.
Moss, K. J.
Pinegar, K. G.
Zeratsky, J. D.

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McInnis, W. R.

Markesan:

Cupery, D. P.
Davis, J. B.
Stuessy, M. F.

Marshfield:

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Bowerman, C. T.
Burns, J. L., Jr.
Caramela, C. M.
Custer, G. S., Jr.
Doege, K. H.
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Emanuel, D. A.
Epstein, Stephan
Glassy, F. J.
Gouze, F. J.
Griese, G. G.
Heersma, J. R.
Helland, N. J.
Heywood, W. H.
Kinkella, A. M.
Larkin, W. B.
Lawton, B. R.
Lewis, R. F., Jr.
Macht, A. J.
Magnin, George E.
Manier, J. W.
Mason, R. W.
McCormick, G. L.
Osborne, J. V.
Ousley, J. L.
Potter, R. P.
Rice, T. J.
Rowe, R. J.
Rupel, J. W.
Schloesser, L. L.
Smiley, D. P.
Smith, R. L.
Suits, J. J.
Taylor, R. D.
Vedder, C. A.
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Wickham, J. M.
Williams, G. H.
Wink, R. H.

Mauston:

Griffin, V. M.
Hess, J. S.
Tverberg, M. S.
Vedner, J. H.

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Bachhuber, F. G.
Parish, G. A.
Royce, M. E.

Mazomanie:

Schultz, Isadore

Medford:

Meyer, W. W.
Nystrum, L. E.
Nystrum, R. C.

Mellen:

Lockhart, C. W.

Menasha:

Bailey, Wallace
Conway, J. E.
De Morest, H. F., Jr.
Forkin, G. E.
Hildebrand, G. B.
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Horn, G. O.
Jensen, F. G.
Jensen, R. A.
Nebel, J. R.
Pratt, G. N., Jr.
Schwei, G. P.

Menomonee Falls:

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Chisholm, D. E.
Domann, W. A.
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Harrington, K. J.
Heyrman, D. J.
Leenhouts, K. C.
Schloemer, H. F.

Menomonie:

Buckley, C. H.
Drescher, A. A.
Gardner, Robert J.
Halgren, J. A.
Lee, S. R.
Lumsden, William
McMahon, A. E.
Neldner, K. H.
Nolan, J. L., Jr.
Quilling, P. A.
Steves, B. J.

Mercer:

Kleinboehl, J. W.

Merrill:

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Bigalow, J. F.
Braun, W. E.
Kelley, F. H.
Lane, F. C.
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Ravn, E. O.
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Middleton:

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Heighway, T. F.
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Milltown:

Ericksen, D. M.

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Burdick, H. L.
Davis, M. D.
Lyons, R. P.

Milton Junction:

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Askot, M. M.
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Baker, V. L.
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Berner, C. L.
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Verch, L. H.
Verdone, A. J.
Voet, R. K.
Wade, Chester
Wagner, G. R.
Wagner, Marvin
Wagner, P. C.
Waisbren, B. A.
Waisman, R. C.
Waldeck, E. A.
Walker, L. J.
Wallner, E. F.
Walton, W. B.
Warner, R. C.
Warschauer, Bruno
Warth, C. G.
Washburn, R. G.
Watson, H. J., Jr.
Watson, R. R.
Watts, Alice D.
Waxman, S. I.
Webb, W. C.
Weber, A. J.
Weber, J. E.
Weber, M. L.
Wegmann, G. H.
Wegmann, N. J.
Weil, H. R.
Wein, Benjamin
Weingartin, Maxwell
Weinshel, L. R.
Weinstein, J. D.
Weisel, Wilson
Weisfeld, S. G.
Weisfeldt, S. C.
Weller, E. A.
Weller, R. R.
Wells, Marvin
Welsh, E. C.
Wendt, W. P.
Wepfer, J. F.
Werba, D. R.
Werner, D. J.
Westhofen, R. C.
Wetzler, S. H.
Whalen, G. E.
Whitaker, P. J.
Wiener, Kurt
Wiese, M. E. J.
Wild, J. P.
Wilets, J. B.
Wilets, J. C.
Wilhoite, R. W.
Williams, DeLore
Willson, D. M.
Winnik, D. E.
Wirthwein, C. L.
Wisniewski, P. P.
Witte, D. H.
Wolfe, C. W.
Woloschek, W. J.
Wolter, S. H.
Wolters, H. F.
Wong, V. J.
Worm, G. J.
Worman, L. W.
Wright, H. H.
Wyman, J. F.
Wynn, S. K.
Yatso, M. G.
Yellick, C. W.
Yunck, R. E.
Zahl, W. H.
Zaun, J. J., Jr.
Zautcke, A. B., Jr.
Zawodny, S. E.
Zell, J. R.
Zeps, A. A.
Ziegler, C. T.
Zillmer, Helen J.
Zimmer, J. F.
Zimmermann, B. M.
Zmyslony, W. P.
Zubatsky, D. J.
Zupnik, G. R.

Mineral Point:

Hamlin, W. D.
Hohler, E. J.
Ludden, H. D.
White, C. L.

Minocqua:

Ashe, H. S.
Huber, G. W.
Sprague, J. P.

Mondovi:

Johnson, B. F.
Meyer, C. F.
Sharp, D. S.
Wright, W. E.

Monroe:

Barry, G. R.
Baumle, C. E.
Bear, N. E.
Brunkow, B. H.
Cales, J. O.
Eckstam, E. E.
Fencil, W. J.
Frantz, J. A.
Harrold, B. D.
Irvin, J. M.
Kindschi, L. G.
Kundert, F. W.
Miller, C. O.
Mings, D. E.
Moore, L. A.
Olson, M. J.
Snowden, P. W.
Springer, D. W.
Stiles, F. C.
Weir, J. R.
Witte, K. B.
Zach, R. G.
Zupanc, E. A.

Montello:

Federman, E. H.
Inman, R. F.

Monticello:

Stovall, W. D., Jr.

Montreal:

Baird, H. D.
Pierpont, J. M.

Mosinee:

Knoedler, W. H., Jr.

Mount Calvary:

Habermann, J. H.
Miller, J. F.

Mount Horeb:

Morrison, M. T.

Mukwonago:

Kern, E. E.

Muscoda:

Ackerman, E. T.
Klockow, W. E.

Muskego:

Buhl, J. L.
Kelm, G. J.

Neenah:

Anderson, G. R.
Beatty, S. R.
Beglinger, H. F.
Bonfiglio, R. G.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Graham, A. P.
Hardie, G. H.
Henning, Laura E.
Henning, R. E.
Kirchgeorg, Clemens
Pansch, F. N.
Petersen, G. W.
Quade, R. H.
Regan, D. M.
Ryan, D. J.
Schwab, R. L.
Smith, F. H.
Springer, V. G.
Suechting, R. L.
Talbot, A. E.

Neillsville:

Lyne, B. W.
Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
Rosekrans, Sarah D.
Thompson, T. N., Jr.

Nekoosa:

Pfeiffer, L. R.
Thompson, J. E.

Neopit:

Hogan, John

New Franken:

Looze, J. A.

New Glarus:

Hicks, E. V.
Marty, P. H.

New Holstein:

Engel, A. C.
Larme, F. P.

New Lisbon:

Koch, C. B.
Weston, C. L.

New London:

Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

New Richmond:

Armstrong, J. H.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Healy, J. P.
Weisbrod, L. W.

Niagara:

Maginn, Richard J.
McCormack, E. A.

Norwalk:

Allen, J. S.

Oconomowoc:

Burch, R. N.
Claude, J. L.
Driscoll, L. J.
Frank, E. B.
Gallo, G. L.
James, W. D.
Janssen, W. C.
Loughnan, A. J.
Matt, J. R.
Miller, G. D.
Nammacher, T. H.
Rheineck, A. F.
Rogers, A. F.
Schuele, D. T.
Schumacher, J. P.
Stemper, Irene T.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

Oconto:

Aageson, H. A.
Mohler, G. T.
Rogers, R. J.
Slaney, A. F.
Zantow, F. E.

Oconto Falls:

Culver, J. R.
Siefert, C. E

Ogema:

Rinehart, B. M.

Omro:

Peck, D. D.
Schoenbechler, L. J.

Onalaska:

Gray, R. H.
Reay, G. R.

Oregon:

Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:

McNair, E. R.

Osceola:

Simenstad, J. O.
Simenstad, L. O.
Weller, L. J.

Oshkosh:

Apell, M. G.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Brei, F. A.
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, H. J.
Danforth, Q. H.
Emrich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, O. F.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Haubrick, H. J.
Hillenbrand, H. M.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Leibenson, S. J.
Lockhart, J. W.
Meilicke, C. A.
Meli, J. V.
Monday, Harvey
Pfefferkorn, E. B.
Romberg, H. A.
Scheuermann, N. M
Steele, G. A.
Steen, M. H.

Stone, L. H.
Strakosch, E. A.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Winter, E. F.
Wright, E. N.
Zmolek, E. J.

Osseo:
Knutson, Oscar
Leasum, R. N.

Owen:
Braswell, H. M., Jr.

Palmyra:
Handeyside, R. G.

Pardeeville:
Westcott, T. S.
Winkler, H. A.

Park Falls:
Leahy, J. D.
Leahy, J. J.
Murphy, J. L.

Pell Lake:
Roenau, Elly A.

Peshtigo:
Barrette, Antoine
Blahnik, C. L.

Pewaukee:
Egloff, L. W.
Kelly, J. P.

Phelps:
Schmitt, R. W.

Phillips:
Niebauer, W. E.
Rens, J. L.
Van Hecke, D. S.

Plain:
Fowler, Paul H.
Galarnyk, I. A.

Platteville:
Andrew, C. H.
Cunningham, Wilson
Doeringsfeld, H. L.
McCumber, M. L.
Moffett, J. L.
Steidinger, C. L.

Plymouth:
Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Mueller, J. F.
Radloff, A. C.
Steffan, L. J.
Watson, Mark
Weisse, H. A.

Portage:
Cooney, R. T.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.

Port Edwards:
Backus, O. A.

Port Washington:
Barr, A. H.
Henkle, R. F.
Kauth, C. P.
Savage, G. F.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.
Stevenson, D. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Satter, O. E.
Shapiro, H. L.

Prairie du Sac:
Trautmann, Milton
Zauft, G. W.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Brusky, S. F.
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Bacon, G. A.
Baernstein, H. D.
Barina, H. J.
Bennett, W. H.
Bliwas, Arnold
Brehm, H. G.
Brehm, H. J.
Brewer, G. W.
Bruton, J. T.
Buckley, W. E.
Burch, V. J.
Caton, J. R.
Christensen, F. C.
Christenson, C. W.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
Dockery, J. N.
Docter, C. W.
Docter, J. C.
Donnell, W. S.
Dorman, T. W.
Edward, A. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Fogle, R. J.
Gehring, C. A.
Gillett, G. N.
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Harris, W. C.
Hemmingsen, T. C.
Henken, J. F.
Henken, W. F.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Holman, J. H.
Jacobsen, A. J.
Jamieson, J. G.
Johnson, P. S.
Jones, Beatrice O.
Jones, L. E.
Kadin, Maurice
Kehl, K. C.
Keland, H. B.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Kurten, R. M.
Lauerman, E. P.
Lehner, R. H.
Leitschuh, R. B.
Lifschutz, L. M.
Lindner, A. M.
Little, W. J., Jr.
MacVicar, E. L., Jr.
Madden, W. J.
Marek, F. B.
Markovitz, J. M.
Mayer, R. J.
McHale, J. A.
Miller, H. C.
Miller, P. L.
Miller, W. C.
Minton, Richard
Nelson, M. W.
Newman, C. R.
Nickelsen, J. R.
Olson, E. S.
Petersen, J. J. G.
Pfeifer, E. C.
Pinkus, W. H.
Pope, F. W.
Postorino, J. D.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schroeder, H. T.
Schuster, Myron
Skow, G. D.
Skupniewicz, R. E.
Smith, L. W.
Smollen, W. J.
Smullen, G. H.
Steffen, Elizabeth A.
Stika, E. A.
Thackeray, R. C.
von Jarchow, B. L.
Walters, H. G.
Williamson, W. H
Wright, R. S.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Stadel, E. V.
Tibbitts, J. A.

Reedsville:
Cary, E. C.

Rhinelander:
Brown, J. F.
Bump, W. S.
Cline, Frances A.
Connors, D. M.
Haug, Thomas M.
Johnson, A. G.
Osborne, R. R.
Pratt, G. F.
Richards, C. A.
Schiek, I. E.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Ribb Lake:
Pettera, R. L.

Rice Lake:
Cotts, L. R.
Eidsmoe, N. A.
MacMillan, D. G.
Maser, J. F.
McKenzie, J. R., Jr.
Rydell, O. E.
Rydell, W. B.
Vaudreuil, W. F.

Richland Center:
Crandall, G. H.
Edwards, W. C.
Glise, Roy C.
Hinke, D. H.
Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, B. I.
Pippin, L. M.
Sholtes, C. A.
Spear, Jack
Taft, D. J.

Rio:
Grundset, H. M.
Maas, W. C.

Ripon:
Bachus, A. C.
Cole, D. F.
Dittmer, O. A
Johnson, J. M.
La Ham, J. T.
Pelton, R. S.
Schuler, W. H.
Sundeen, R. A
Watson, E. L.

River Falls:
Cairns, R. U
Furr, L. O.
Grassl, F. O.
Gutzler, P. H.
Haskins, P. S

Rosholt:
Benn, V. A.

St. Croix Falls:
Belshe, J. C.
Riegel, F. B.
Riegel, J. A.
Wegner, M. E

St. Nazianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A
Kraus, B. F.
Walsh, T. W

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Schrock, J. B.

Shawano:
Arvold, D. S.
Bauer, Frederick
Cantwell, A. A.
Cantwell, R. C.
Jeffries, Donald A.
Laufenburg, H. F.
Marsh, H. C.
Peterson, L. W.
Sebesta, A. J.
Toll, R. J.
Von Ruden, W. J.

Sheboygan:
Bassewitz, P. P.
Bock, A. B. C.
Bringe, J. W.
Cinelis, Ann A.
Differt, C. C.
Duckering, Florence A.
Eckardt, B. F.
Eigenberger, Friedrich
Evensen, N. A.
Gruenewald, Ludwig
Heinz, H. N.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Houfek, E. E.
Hougen, E. T.
Huibregtse, W. G.
Juckem, G. J.
Knauf, A. J.
Kolb, F. K.
Kovacic, J. F.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Moir, Jane M.
Moir, W. W.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Pfeiler, A. G.
Schott, E. G.
Schroeder, I. L.
Sciarra, P. A.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Sorensen, E. T.
Stannard, G. H., Jr.
Tasche, C. T.

Tasche, J. A.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Windsor, R. B.
Winsauer, H. J
Wood, H. R.
Wood, R. A.
Zaegel, R. L.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Weygandt, J. L.

Shell Lake:
Moen, D. V.
Welter, D. J.

Shiocton:
La Croix, G. M.

Shullsburg:
Garland, D. J.
Gratiot, Mary P.
Hoesley, H. F.

Silver Lake:
De Witt, C. A

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
Gredler, G. P.
Grimm, J. J.
Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Palese, J. A.
Theisen, C. E.

Sparta:
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Harrls, A. J.
Lukasek, E. O.
Mannis, Harry
Van Susteren, J. A.
Williams, H. H., Jr.

Spencer:
Callahan, H. T.

Spooner:
Goetsch, F. H.
Olson, L. J.

Spring Green:
Rosemeyer, O. G.

Spring Valley:
Hill, E. F.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Bickford, R. H.
Crosby, E. P.
Dunn, A. G.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
lber, F. C.
Kohn, A. M.
Litzow, J. A.
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Sanders, R. H.
Sauer, J. P.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.
Wisiol, Erich

Stockbridge:
Knauf, J. A.

Stoughton:
Hermundstad, O. A.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, R. F.
Smedal, A. T.

Stratford:
Kroeplin, F. C.

Strum:
Walker, J. P.

Sturgeon Bay:
Beck, J. G.
Brook, J. J., Jr.
Dorchester, D. E.
Grota, H. D.
Hobson, W. S.
Muehlhauser, J. O.
Murphy, J. T.
Peters, H. R.
Sheets, W. G.

Sun Prairie:
Behrend, J. F
Grab, J. A.
Nelson, E. J.
Peterson, Leo W.
Russell, W. T.

Superior:
Anderson, R. T.
Carpenter, E. E.
Doyle, T. J.
Droege, C. T.
Ekblad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Charles W.
Giesen, Conrad W.
Heisel, J. G.
Johnson, F. G., Jr.
Lavine, I. H.
Lavine, M. M.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Rosin, L. R.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.
Weisberg, J. H.

Suring:
Sandgren, G. R.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.
Langenfeld, P. F.

Thiensville:
Elbe, T. D.
Herman, Murray
Levy, E. S.
Scholz, H. F.

Thorp:
Jorgensen, Eleanora F.
Jorgensen, P. B.
Neis, F. P.

Tigerton:
Heise, L. F.
Maurer, Siegfried
Rogers, R. M.

Tomah:
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A
Mubarak, J. S.
Rouman, W. C.

Tomahawk:
Adams, H. G.
Baker, G. R.
Baker, R. G.
Jarvis, D. F.
Jarvis, E. C.
McCormick, W. C

Turtle Lake:
Halberg, A. C.

Two Rivers:
Kozelka, A. W.
Kuljis, D. A.
Martin, R. E.
Nilles, J. E.
Weld, S. L.
Zlatnik, A. P.

Union Grove:
Haedike, W. D.
McCracken, R. W
Ptacek, L. J.
Schulz, G. J.

Valders:
Acheson, W. E.

Verona:
Knight, C. C.

Viola:
Meboe, Joseph

Viroqua:
Ender, C. A.
Gulbrandsen, L. F
Hirsch, R. S.
Kuehn, A. E.
Oppert, H. D.
Skinsnes, C. C.
Starr, R. A.
Vig, D. E.
Vig, De Verne W
Vig, E. N.

Wabeno:
Tenley, O. S.

Walworth:
Coon, W. W.
Kroyer, T. J.

Washburn:
Guzzo, Harold

Waterford:
Bardenwerper, H. W.
Dietz, R. J.

Waterloo:
Fowler, J. R.
Kennedy, F. H.
Schmidt, C. W.

Watertown:
Becker, J. H.
Burzynski, E. E.
Dierker, O. F.
Doyle, R. F.
Epperson, D. P.
Hahn, A. C
Marshall, W. S.
Miller, E. A.
Nowack, L. W.
Welbourne, R. P.
Zimmermann, F. H

Waukesha:
Bartos, J. A.
Bolger, James V.
Brown, W. E.
Campbell, P. E.
Campbell, W. B
Carroll, P. E.
Clothier, W. J. K.
Davies, E. B.
Davies, Gwilym
Dugan, T. E.
Edmondson, C. C.
Feulner, R. C.
Frantz, R. G.
Frick, J. C.
Gantz, H. A.
Grosskopf, E. C
McDonell, T. H.
Merkow, William
Motzel, A. J., Jr.
Promer, J. E.
Scheele, F. M.
Schoene, F. C.
Schulz, E. G.
Selle, F. S.
Settlage, H. A
Smirl, W. G.
Sweed, Aaron
Sydow, H. F.
Thompson, F. A
Werra, B. J.
Werra, M. J.
Werra, R. J
Wood, C. A.
Zietlow, F. G

Waunakee:
Marquis, W. R
Waters, D. D.

Waupaca:
Boudry, M. O.
Haman, K. L.
Salan, Sam
Steiner, J. H.

Waupun:
Hebenstreit, A. J
Hull, H. H.
Larimore, O. M
Peterson, J. A.
Petters, W. J.
Reslock, C. P.
Schrank, L. W.
Schrank, R. E.
Wagner, W. A

Wausau:
Bachhuber, G. J.
Balliet, C. M.
Bartholomew, R. D
Becker, W. T.
Brick, E. B.
Brodhead, R. H.
Burr, Thurl C., Jr.
Christensen, H. W
Davis, Helen Crawford
Fechtner, H. H.
Fehland, H. R.
Flannery, J. V.
Flemming, E. E.
Foerster, J. M.
Freeman, D. J.
Freeman, J. M.
Grauer, C. G.
Green, D. M.
Hammes, G. R
Hendrickson, A. O
Hendrickson, W. O
Hoessel, A. W.
Johnson, F. C.
Jones, M. L.
Kass, R. M.
Kelley, O. R.
Kline, C. L.
Kordiyak, George
Kramer, J. D.
Larsen, R. B.
Locher, W. G.
Ludwig, E. P.
Mallery, O. T.
McCandless, E. E
Miller, W. C.
Molinaro, A. J.
Mulvaney, J. J
Norton, W. I
Prehn, F. C.
Rudy, W. B.
Schroth, G. J.
Shannon, R. C.
Smith, B. K.
Smith, S. M. B.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
Struthers, J. L.
Trumbo, J. K
Venables, A. J
Wersich, W. W.
Wilson, O. M.
Yoran, C. M.

Wautoma:
Beck, A. A.
Darby, R. C.
Shemanski, L. S.
Slattery, F. G.

Wauwatosa:
Appleby, K. B.
Beck, K. H.
Beltran, D. J.
Boyle, R. W.
Brand, W. D.
Brandt, E. F.
Brook, J. J.
Burgardt, G. F.
Cadden, A. V.
Cook, H. M.
Curtis, William C.
Danziger, Lewis
Denio, M. J., Jr.
Dettmann, N. F.
Deysach, L. J.
End, E. M.
Engstrom, W. W.
Feierstein, W. E.
Foregger, Richard
Glienke, C. F.
Harkness, John W.
Headlee, C. R.
Hunkel, V. H.
Jaastad, L. B.
Kehlnhofer, F. H.
Klopfer, W. P.
Kradwell, W. T.
Liefert, K. A.
Lorton, W. L.
McCann, Edith F.
McCormick, G. E.
McDermott, J. F.
Nordin, P. F.
O'Connell, James R
Osgood, C. W.
Pendergast, T. J.
Ricciardi, I. J.
Sanders, A. C.
Selfert, K. A.
Seymer, L. A.
Turrell, E. S.
Whetstone, O. H.
Winters, K. J.
Wood, D. L.
Wyland, J. S.

Webster:
Maas, D. A.

West Allis:
Bertolaet, E. E.
Biljan, M. W.
Brumbaugh, E. V.
Collins, E. G.
Couch, J. R.
Couch, T. T.
Cramer, R. P.
Everts, E. L.
Fais, O. G.
Frederick, R. H.
Fulton, J. W.
Gambino, S. R.
Heinan, F. C.
Hermann, W. C.
Joseph, W. A.
Malensek, M. C.
Mallin, Isadore
Miller, L. E.
Miner, D. L.
Nefches, M. S.
Ohlsen, M. P.
Smits, R. H.
Stamm, M. P.
Stern, C. S.
Stern, L. S.
Stern, R. S.
Toepfer, R. A.
Wilkinson, E. D.
Wilkinson, J. J.
Zenz, Carl
Zimmer, J. J.

West Bend:
Bauer, K. T.
Baumgartner, J. F.
Bush, F. I.
Driessel, R. H.
Frankow, R. O.
Gibson, R. D.
Grundahl, A. T.
Heidner, A. H.
Koehler, J. P.
Nielsen, W. A.
Scheunemann, W. E.
Sorensen, R. F.

West De Pere:
Lenz, R. B.

West Salem:
Goedecke, R. H.
Lloyd, B. E.
Morris, D. L.
Wakefield, G. F.

Westfield:
Bland, P. T.
Otterson, W. N.

Westby:
Fredrick, H. Y.

Weyauwega:
Maasch, L. P.

Whitefish Bay:
Gruender, J. E. M.

Whitehall:
Gettelman, S. T.
MacCornack, R. L., Sr.
Simons, N. S.
Tschetter, J. S.

Whitelaw:
Gutheil, D. A.

Whitewater:
Ambrose, S. H.
Miller, R. H.

Wild Rose:
Kjentvet, R. A.
Wichmann, R. D.

Williams Bay:
Wiswell, C. Y.

Winnebago:
Bachhuber, H. M.
Colgan, H. J.
Kubiak, Mary K.
Loftus, E. R.
Petersik, J. T.

Winneconne:
Brannon, G. H.
McDonald, D. H.

Wisconsin Dells:
Broderick, C. F.
Gissal, F. W.
Houghton, J. H.

Wisconsin Rapids:
Arendt, C. J.
Arendt, N. W.
Debus, E. E.
Garrison, R. E.
Glenn, E. C.
Handy, G. H.
Hulme, A. W.
Nelson, W. L.
Pomainville, H. G
Pomainville, L. C
Schaller, J. W.
Shields, G. G.

Withee:
Johnson, J. W.

Wittenberg:
Olson, M. H.

Wonewoc:
Baker, H. P.

Wood:
Bemis, E. L.
Bittle, K. A.
Bormes, R. E.
Cohen, A. M.
Dessel, B. H.
Dudenhoefer, P. A.
Hartman, A. S.
Kory, R. C.
Leitschuh, T. H.
Levin, J. J.
Mahaffey, C. H.
Mateicka, W. E.
Meade, R. C.
Piaskoski, R. G.
Schuh, E. P.
Spector, J. A.
Spencer, G. N.
Weisenthal, C. L.

Woodruff:
Hiatt, W. R.
Pfeiffer, O. W.

Woodville:
Heiser, P. Arthur

Wrightstown:
Vande Loo, F. B.

Wyocena:
de Neveu, A. V.

No Known Address:
Boyce, S. R.
McGonigle, B. E.

Out-of-State Members

Allen, L. L. ---------- Philadelphia, Pennsylvania
Aszman, P. E. ---------- Miami, Florida
Baldzikowski, R. A. ---------- Rochester, Minnesota
Banyai, A. L. ---------- Chicago, Illinois
Barrow, D. W. ---------- San Francisco, California
Baum, E. L. ---------- Naples, Florida
Bleyer, L. F. ---------- Providence, Rhode Island
Brooks, J. W. ---------- Richmond, Virginia
Claypool, B. W., Jr. ---------- Rochester, Minnesota
Coffin, L. E. ---------- Tucson, Arizona
Cornelius, E. A. ---------- Houston, Texas
Costello, W. H. ---------- Phoenix, Arizona
Creasy, L. E. ---------- St. Petersburg, Florida
Crockett, R. F. ---------- Kingsburg, California
Currie, R. E. ---------- Los Angeles, California
Davee, Chalmer ---------- Marion, Illinois
Davis, D. P. ---------- Fategharg, U.P., India
Deering, H. C. ---------- Norwalk, California
Demke, R. L. ---------- Rushville, Illinois
Doermann, P. E. ---------- Madang, Territory of New Guinea
Dunham, C. T. ---------- Bartow, Florida
Fabric, B. L. ---------- Hallandale, Florida
Foderick, P. P. ---------- Hallock, Minnesota
Fox, G. E. ---------- Springfield, Illinois
Froede, H. E. ---------- Washington, D. C.
Gaspar, H. E. ---------- Louisville, Kentucky
Grant, L. C., Jr. ---------- North Nigeria, West Africa
Grueninger, A. J. ---------- Colorado Springs, Colorado
Harkavy, Raymond ---------- Cleveland, Ohio
Harter, A. F. ---------- Eveleth, Minnesota
Heeb, H. J. ---------- Howey-in-the-Hills, Florida
Henke, F. W. ---------- Edina, Minnesota
Herbert, E. A. ---------- Willimantic, Connecticut
Herlitzka, A. J. ---------- Mason City, Iowa
Holbrook, A. T. ---------- Dunedin, Florida
Holt, A. H. ---------- Youngstown, Ohio
Horning, J. S. ---------- Ecuador, South America
Howlett, J. R. ---------- Seattle, Washington
Huckle, G. T. ---------- Delray Beach, Florida
Iwen, G. W. ---------- Dallas, Texas
Johnson, H. C. ---------- Eugene, Oregon
Kemp, G. B. ---------- Riverside, Pennsylvania
Kempton, L. V. ---------- Villa Park, Illinois
Klobucar, J. J. ---------- La Mirada, California
Lepley, Derward, Jr. ---------- St. Paul, Minnesota
Mac Cornack, R. L., Jr. ---------- South St. Paul, Minnesota
McKenzie, L. J. ---------- Urban, Illinois
Megna, Salvatore ---------- Tucson, Arizona
Middleton, W. S. ---------- Washington, D. C.
Noble, P. R. ---------- Saginaw, Michigan
O'Donnell, Mae J. ---------- Wadsworth, Kansas
O'Neill, J. W. ---------- Boulder City, Nevada
Pedersen, Elaine K. G. ---------- Spokane, Washington
Peterson, F. N. ---------- Boston, Massachusetts
Philpot, V. B., Jr. ---------- Memphis, Tennessee
Puchner, T. C. ---------- Minneapolis, Minnesota
Reibold, F. W. ---------- Carroll, Iowa
Rivard, R. R. ---------- Holyoke, Massachusetts

Sanders, J. I. ----------Brighton, Massachusetts
Sargeant, H. W. ----------Long Prairie, Minnesota
Schmidt, C. W. ----------Kansas City, Kansas
Seno, E. C. ----------Knoxville, Iowa
Smith, T. D. ----------Calabasas, California
Sorenson, J. M. ----------Rochester, Minnesota
Stackpole, J. W. ----------Burlington, Vermont
Stebbins, W. W. ----------St. Petersburg, Florida
Stokdyk, G. A. ----------Santa Cruz, California
Sullivan, J. J. ----------Carmichael, California
Sweeney, T. C. ----------Cleveland, Ohio
Taylor, L. D. ----------Aberdeen, South Dakota
Theil, G. B. ----------San Lorenzo, California
Van Kirk, F. W., Sr. ----------San Francisco, California
Van Riper, H. E. ----------Yonkers, New York
Vivian, R. S. ----------Naples, Florida
Ward, C. E. ----------Delaware, Ohio
Wells, May R. ----------Belleville, Illinois
White, D. H. ----------Indianapolis, Indiana
White, E. F. ----------Harlingen, Texas

Members Serving in the Armed Forces

Bailey, D. W. ----------Berkeley, California
Boyd, Andrew, Jr. ----------New London, Connecticut
Brady, J. J. ----------Albany, Georgia
Bultema, J. H. ----------Muskegon, Michigan
Enders, L. J. ----------Montgomery, Alabama
Goodfriend, R. B. ----------New York, New York
Gordon, J. J. ----------San Lorenzo, California
Gosin, R. F. ----------West Covina, California
Grade, J. O. ----------Elm Grove, Wisconsin
Hampel, D. C. ----------Milwaukee, Wisconsin
Howland, D. E. ----------Wichita Falls, Texas
Kennedy, W. F. ----------Ft. Lewis, Washington
Kinsey, J. L. ----------Washington, D. C.
Kowalski, A. M. ----------Lawton, Oklahoma
Kratchovil, C. H. ----------Randolph AFB, Texas
Kreissl, L. J., Jr. ----------Santa Rosa, California
Krohn, J. I. ----------Black River Falls, Wisconsin
Mataczynski, R. R. ----APO 139, New York, New York
McCabe, L. B. ----------Ft. Sam Houston, Texas
Nelson, P. D. ----------Philadelphia, Pennsylvania
Nemec, George, Jr. ----------Greenwood, Wisconsin
Newton, R. M. ----------New Orleans, Louisiana
Orlovsky, J. F. ----------Ft. Sheridan, Illinois
Quinn, G. A. ----------Milwaukee, Wisconsin
Richter, A. M. ---------APO 305, New York, New York
Rumhoff, Gordon---APO 24, San Francisco, California
Sachtjen, K. M. ----------Bossier City, Louisiana
Schatz, W. R. ----------Racine, Wisconsin
Schmidt, C. H. ---------APO 283, New York, New York
Semmens, J. P. ----------Charleston, South Carolina
Shon, C. M. ----------F80, San Francisco, California
Simenstad, P. O. ----------Osceola, Wisconsin
Stergiades, F. G. ------APO 949, Seattle, Washington
Valaske, M. J. ----------Jacksonville, Florida
Ward, V. G. ----------Palisade, Nebraska
Zastrow, R. C. ----------Bremerton, Washington

Honorary Members

Bradley, H. C., Ph.D. ----------Oakland, California
Clark, P. F., Ph.D. ----------Madison
Foerster, O. H. ----------Milwaukee
McCracken, R. W. ----------Union Grove
McMahon, H. O. ----------Milwaukee
Meek, W. J., Ph.D. ----------Ft. Myers Beach, Florida
Miller, E. W. ----------Milwaukee
Mortensen, O. A. ----------Madison
Pusey, W. A., Ph.D. ----------Chicago, Illinois
Shideman, F. E. ----------Madison
Sisk, I. R. ----------Madison
Sullivan, W. E., Ph.D. ----------San Antonio, Texas

Life Members

Allen, W. J. ----------Beloit
Baker, G. R. ----------Tomahawk
Bayer, W. H. ----------Merrill
Beebe, S. D. ----------Sparta
Bolton, E. L. ----------Appleton
Boyce, S. R. ----------No known address
Brehm, H. J. ----------Racine
Brooks, E. H. ----------Bloomington
Brunckhorst, F. O. ----------Neenah
Cairns, R. U. ----------River Falls
Campbell, W. B. ----------Waukesha
Connell, F. G. ----------Oshkosh
Crockett, W. W. ----------Beloit
Crosby, E. P. ----------Stevens Point
Cunningham, Wilson ----------Platteville
Epley, O. H. ----------New Richmond
Fazen, L. E. ----------Racine
Forkin, G. E. ----------Menasha
Fuller, M. H. ----------Green Bay
Gavin, S. E. ----------Fond du Lac
Giesen, Charles W. ----------Superior
Grosskopf, E. C. ----------Waukesha
Hammond, F. W. ----------Manitowoc
Haubrick, H. J. ----------Oshkosh
*Heeb, H. J. ----------Milwaukee
Junck, J. A. ----------Milwaukee
Kelley, F. H. ----------Merrill
Kleinboehl, J. W. ----------Mercer
Knauf, N. J. ----------Chilton
Kradwell, W. T. ----------Wauwatosa
Leonard, C. W. ----------Fond du Lac
Lockhart, C. W. ----------Mellen
Lockhart, J. W. ----------Oshkosh
Ludden, H. D. ----------Mineral Point
Lumsden, William ----------Menomonie
Madison, J. D. ----------Milwaukee
Marshall, V. F. ----------Appleton
Mason, E. L. ----------Eau Claire
Meusel, H. H. ----------Fond du Lac
Pope, F. W. ----------Racine
Potter, R. P. ----------Marshfield
Radloff, A. C. ----------Plymouth
Raymond, R. G. ----------Brownsville
Schmidt, E. S. ----------Green Bay
Schmit, Louis ----------Milwaukee
Smith, S. M. B. ----------Wausau
Stebbins, W. W. ----------St. Petersburg, Florida
Tasche, C. T. ----------Sheboygan
Thomas, W. O. ----------Clinton
Twohig, D. J. ----------Fond du Lac
Washburn, R. G. ----------Milwaukee
*Wetzler, S. H. ----------Milwaukee
Wheeler, W. P. ----------Oshkosh

* Granted life membership in 1958.

The State Medical Society of Wisconsin

1958–1959 Officers and Councilors

President
Dr. W. B. Hildebrand
59 Racine Street
Menasha

Secretary
Mr. C. H. Crownhart
330 East Lakeside Street
Madison

Assistant Secretaries
Mr. Roy T. Ragatz
Mr. Earl R. Thayer
330 East Lakeside Street
Madison

Treasurer
Dr. F. L. Weston
1 South Pinckney
Madison

Speaker, House of Delegates
Dr. J. D. Leahy
170 4th Avenue North
Park Falls

Vice Speaker, House of Delegates
Dr. L. H. Lokvam
723 58th Street
Kenosha

Councilors*

(Dr. R. G. Arveson, Frederic, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. W. D. James, Oconomowoc, 1960.

Second: Kenosha, Racine and Walworth County Societies. Dr. L. H. Lokvam, 723 58th Street, Kenosha, 1960.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. Dr. N. A. Hill, 304 West Washington Avenue, Madison, 1961; Dr. J. H. Houghton, 132 Washington Avenue, Wisconsin Dells, 1960.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1961.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. Dr. P. B. Blanchard, 204 N. Washington Avenue, Cedarburg, 1961.

Sixth: Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Societies. Dr. H. J. Kief, 104 S. Main Street, Fond du Lac, 1961.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. J. C. Fox, 212 South 11th Street, La Crosse, 1959.

Eighth: Marinette–Florence, Oconto, and Shawano County Societies. Dr. J. M. Bell, Marinette, 1959.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. R. E. Garrison, Wisconsin Rapids, 1959.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson (chairman), Frederic, 1959.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1960.

Twelfth: The Medical Society of Milwaukee County. Dr. R. E. Galasinski, 3333 South 27th Street, Milwaukee; Dr. G. S. Kilkenny, 2040 West Wisconsin Avenue, Milwaukee, 1960; Dr. J. P. Conway, 1800 East Capitol Drive, Milwaukee, 1961; Dr. James E. Conley, 425 East Wisconsin Avenue, Milwaukee; Dr. E. L. Bernhart, 2714 West Burleigh Street, Milwaukee, 1959.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. J. D. Leahy, Park Falls, 1959.

Dr. Harry E. Kasten, 419 Pleasant Street, Beloit (past president).

Dr. S. E. Gavin, 104 South Main Street, Fond du Lac, Chairman Emeritus.

Delegates to American Medical Association

Dr. W. D. Stovall (1959)
State Laboratory of Hygiene
Madison

Dr. J. C. Griffith (1959)
944 North Jackson Street
Milwaukee

Dr. L. O. Simenstad (1960)
195 Hammond Street
Osceola

Dr. E. L. Bernhart (1960)
2714 West Burleigh Street
Milwaukee

Alternates

Dr. A. A. Quisling (1959)
2 West Gorham Street
Madison

Dr. R. E. Galasinski (1959)
3333 South 27th Street
Milwaukee

Dr. John M. Bell (1960)
516 Houston Street
Marinette

Dr. J. M. Sullivan (1960)
161 W. Wisconsin Avenue
Milwaukee

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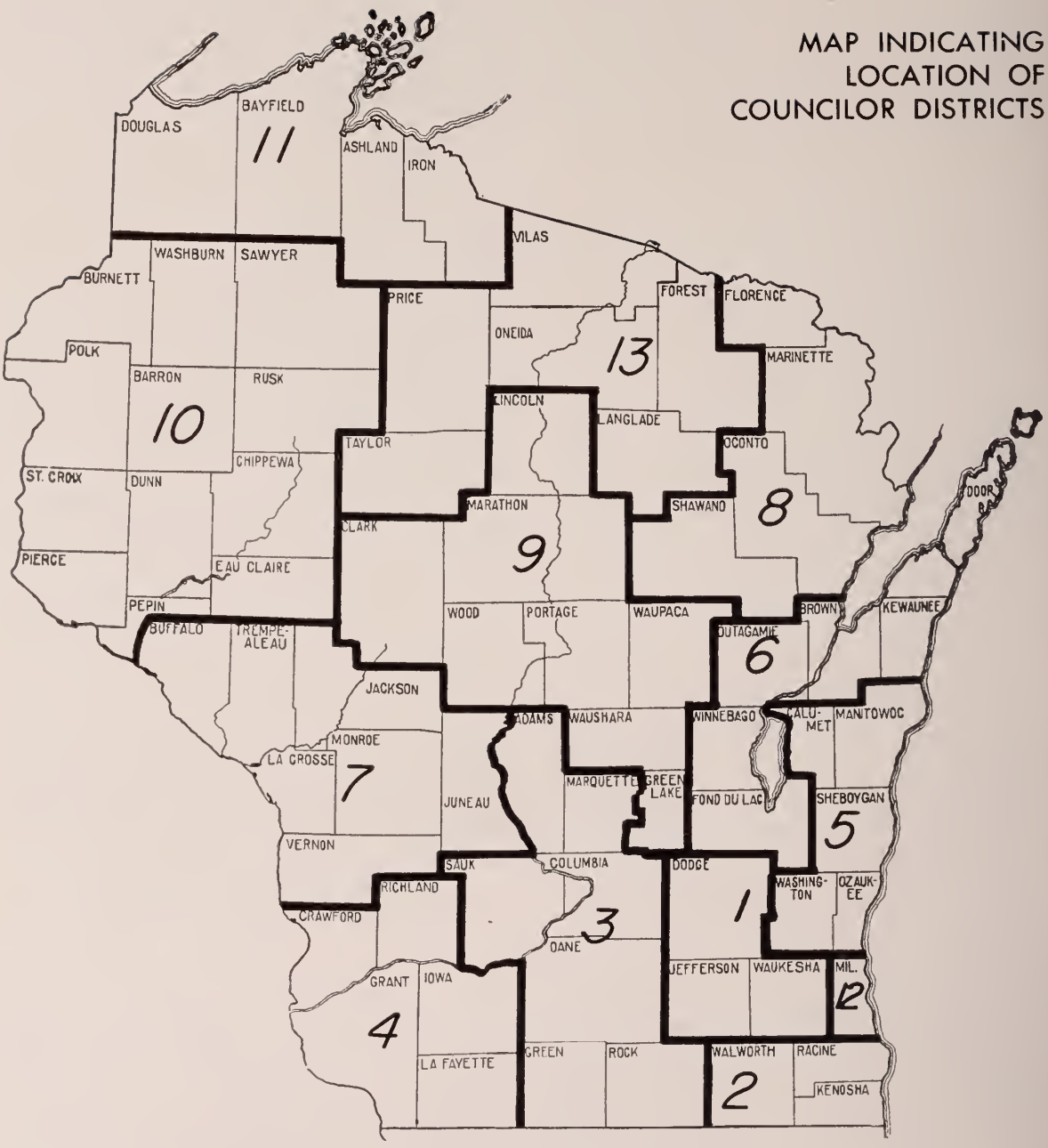
* Map indicating location of councilor districts, page 80.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May.

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



First District:
Dr. W. D. James, Oconomowoc

Second District:
Dr. L. H. Lokvam, Kenosha

Third District:
Dr. N. A. Hill, Madison
Dr. J. H. Houghton, Wisconsin Dells

Fourth District:
Dr. E. M. Dessloch, Prairie du Chien

Fifth District:
Dr. P. B. Blanchard, Cedarburg

Sixth District:
Dr. H. J. Kief, Fond du Lac

Seventh District:
Dr. J. C. Fox, La Crosse

Eighth District:
Dr. J. M. Bell, Marinette

Ninth District:
Dr. R. E. Garrison, Wisconsin Rapids

Tenth District:
Dr. R. G. Arveson, Chairman, Frederic

Eleventh District:
Dr. V. E. Ekblad, Superior

Twelfth District:
Dr. R. E. Galasinski, Milwaukee
Dr. E. L. Bernhart, Milwaukee
Dr. G. S. Kilkenny, Milwaukee
Dr. J. P. Conway, Milwaukee
Dr. J. E. Conley, Milwaukee

Thirteenth District:
Dr. J. D. Leahy, Park Falls

Dr. S. E. Gavin, Chairman Emeritus, Fond du Lac

Standing Committees—1958-1959

Committee on Cancer

Dr. Wirthwein

Carlton Wirthwein, M.D., 1959, chairman, 425 E. Wisconsin Avenue, Milwaukee

R. P. Welbourne, M.D., 1960, 113 North Third Street, Watertown

J. W. Boren, Jr., M.D., 1961, 1510 Main Street, Marinette

W. S. Bump, M.D., 1959, 1020 Kabel Avenue, Rhinelander

E. C. Howell, M.D., 1959, Fennimore

Paul M. Cunningham, M.D., 1960, 401 North Oneida Street, Appleton

P. B. Blanchard, M.D., 1960, 204 N. Washington Avenue, Cedarburg

Clifford A. Grand, M.D., 1960, 522 West Second Street, Ashland

C. W. Stoops, M.D., 1961, 110 E. Main Street Madison

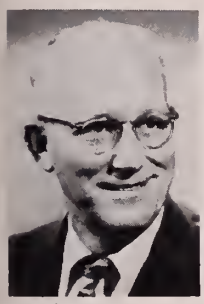
G. I. Uhrich, M.D., 1959, 212 South Eleventh Street, La Crosse

Ralph C. Frank, M.D., 1959, Pine Place, Route 3, Eau Claire

R. J. Schacht, M.D., 1959, 1704 Milwaukee Avenue, Racine

A. H. Stahmer, M.D., 1961, 120 Clarke Street, Wausau

Committee on Grievances


Dr. Sorenson

E. D. Sorenson, M.D., 1959, chairman, 104 S. Wisconsin Street, Elkhorn

R. E. Fitzgerald, M.D., 1960, 2218 North Third Street, Milwaukee

E. W. Mason, M.D., 1959, 324 East Wisconsin Avenue, Milwaukee

E. J. Nordby, M.D., 1961, 2715 Marshall Court, Madison

F. C. Lane, M.D., 1960, 401 W. Main Street, Merrill

H. J. Belson, M.D., 1961, 904A South 8th Street, Manitowoc

R. R. Richards, M.D., 1961, 116 W. Grand Avenue, Eau Claire

C. D. Neidhold, M.D., 1960, 103 West College Avenue, Appleton

J. L. Moffett, M.D., 1959, 107 East Main Street, Platteville

Committee on Hospital Relations

Dr. Hollenbeck

S. W. Hollenbeck, M.D., 1959, chairman, 2650 W. Fond du Lac Avenue, Milwaukee

W. C. Henske, M.D., 1959, 32½ East Spring Street, Chippewa Falls

A. H. Barr, M.D., 1960, 214 North Wisconsin Street, Port Washington

S. R. Beatty, M.D., 1960, 117 North Commercial Street, Neenah

J. P. McCann, M.D., 1961, 503 State Bank Building, La Crosse

E. S. Olson, M.D., 1961, St. Luke's Hospital, Racine

Committee on Medical Education and Hospitals

Dr. Squier

T. L. Squier, M.D., 1961, chairman, 425 East Wisconsin Avenue, Milwaukee

N. M. Clausen, M.D., 1963, 2 West Gorham Street, Madison

I. E. Schiek, Jr., M.D., 1959, 114 West Davenport Street, Rhinelander

J. W. Boren, Jr., M.D., 1960. 1510 Main Street, Marinette

W. S. Freeman, M.D., 1962, 1146 Grant Street, Beloit

John Z. Bowers, M.D., ex officio, 1300 University Avenue, Madison

J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee

Committee on Coordination of Medical Services

J. F. Wilkinson, M.D., 1962, chairman, 114 East Wisconsin Avenue, Oconomowoc

R. S. Gearhart, M.D., 1960, 621 South Park Street, Madison

J. W. Nellen, M.D., 1959, 122 East Walnut Street, Green Bay

S. E. Gavin, M.D., 1961, 104 South Main Street, Fond du Lac

Einar Daniels, M.D., 1963, 2212 W. State Street, Milwaukee

M. O. Boudry, M.D., 1963, 122 S. Main Street, Waupaca

H. E. Oppert, M.D., 1959, 318 South Main Street, Viroqua

E. J. Nordby, M.D., 1960, 2715 Marshall Court, Madison

L. W. Schrank, M.D., 1961, 201 S. Grove Street, Waupun

J. H. Wishart, M.D., 1962, State Street Road, Eau Claire

President, ex officio

Secretary, ex officio

Council on Medical Services

Dr. Willison

D. M. Willison, M.D., 1961, chairman, 314 Grand Avenue East, Eau Claire

J. S. Devitt, M.D., 1961, 944 North Jackson Street, Milwaukee

D. E. Dorchester, M.D., 1960, 10 North Third Avenue, Sturgeon Bay

E. C. Cary, M.D., 1959, Reedsville

J. F. Maser, M.D., 1959, 24 W. Marshall Street, Rice Lake

C. J. Picard, M.D., 1959, 425 21st Avenue East, Superior

R. L. MacCornack, M.D., 1960, Whitehall

H. J. Kief, M.D., 1960, 104 South Main Street, Fond du Lac

W. J. Fencil, M.D., 1961, The Monroe Clinic, Monroe

Committee on Public Policy

A. A. Quisling, M.D., 1961, chairman, 2 West Gorham Street, Madison

J. M. Sullivan, M.D., 1962, 161 West Wisconsin Avenue, Milwaukee

E. T. Rechlitz, M.D., 1963, 419 Pleasant Street, Beloit

J. P. Conway, M.D., 1959, 1800 East Capitol Drive, Milwaukee

Dr. Quisling

S. E. Gavin, M.D., 1960, 104 South Main Street, Fond du Lac

Earl C. Quackenbush, M.D., 1962, 14 North Main Street, Hartford

Robert G. Zach, M.D., 1962, 810 19th Avenue, Monroe

President, ex officio

President-elect, ex officio

Secretary, ex officio

Council on Scientific Work

Dr. Lemmer

K. E. Lemmer, M.D., 1959, chairman, 1300 University Avenue, Madison

M. F. Huth, M.D., 1960, 203 Fourth Street, Baraboo

R. W. Farnsworth, M.D., 1963, 305 Court Street, Janesville

R. B. Larsen, M.D., 1962, 510½ Third Street, Wausau

M. C. F. Lindert, M.D., 1961, 5340 N. Berkeley Boulevard, Milwaukee

R. S. Baldwin, M.D., 650 South Central Avenue, Marshfield

J. S. Hirschboeck, M.D., 561 North Fifteenth Street, Milwaukee

John Z. Bowers, M.D., 1300 University Avenue, Madison

Advisory Committee to Woman's Auxiliary

Chairman of the Council, Chairman

Immediate Past-President

President

President-Elect

Secretary

Council Committees

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

Economic Medicine
Executive
Finance
Planning
Scientific Medicine

Council Committees:

Blood Bank
Civil Defense
Commission on Medical Care Plans
Commission on State Departments
Diabetes
Editorial Board
Division of Surgical Fees
Military Medical Service

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

President ---------- D. N. Goldstein, Kenosha
Secretary ---------- J. A. Kelble, Milwaukee
Delegate ---------- C. J. Picard, Superior
Alternate ---------- D. N. Goldstein, Kenosha

Section on Internal Medicine

Chairman ---------- W. K. Simmons, Rhinelander
Delegate ---------- L. J. Kurten, Racine
Alternate ---------- R. L. Gilbert, La Crosse

Section on Neurology and Psychiatry

Chairman ---------- E. D. Schwade, Milwaukee
Secretary-Treasurer - E. C. Schmidt, Milwaukee
Delegate ---------- David Cleveland, Milwaukee
Alternate ---------- Edward Burns, Madison

Section on Obstetrics and Gynecology

President ---------- William Luetke, Madison
Vice-President ------ H. A. Sincock, Superior
Secretary ---------- John J. Boersma, Green Bay
Delegate ---------- F. J. Hofmeister, Milwaukee
Alternate ---------- E. A. Steffen, Racine
Board of Governors - G. S. Kilkenny, Milwaukee
Dean D. Willson, Fond du Lac
Ralph E. Campbell, Madison

Section on Ophthalmology and Otolaryngology

Chairman ---------- Peter A. Duehr, Madison
Secretary ---------- Ralph T. Rank, Milwaukee
Delegate ---------- H. C. High, Jr., Milwaukee
Alternate ---------- George Nadeau, Green Bay

Section on Orthopedics

President ---------- J. W. Nellen, Green Bay
Secretary-Treasurer - J. E. Kaufman, Green Bay
Delegate ---------- P. K. Odland, Janesville
Alternate ---------- M. W. Nelson, Racine

Section on Pediatrics

(Information not available at time of publication)

Section on Pathology

President ---------- E. L. Schafer, Madison
Vice-President ------ D. B. Claudon, Milwaukee
Secretary-Treasurer - R. S. Haukohl, Milwaukee
Delegate ---------- Gorton Ritchie, Milwaukee
Alternate ---------- E. A. Birge, Milwaukee
Board of Censors --- J. M. Lubitz, chairman, Brookfield
Lester McGary, Madison
J. F. Kuzma, Milwaukee

Section on Public Health

President ---------- E. E. Bertolaet, West Allis
President-Elect ----- A. L. Van Duser, Madison
Secretary-Treasurer - Jean C. Antonmattei, Milwaukee
Delegate ---------- C. K. Kincaid, Madison
Alternate ---------- R. E. Graber, Chippewa Falls
Executive Committee Those named above

Section on Radiology

Chairman ---------- R. W. Byrne, Milwaukee
Secretary-Treasurer - C. E. Schmidt, Milwaukee
Delegate ---------- W. T. Clark, Janesville
Alternate ---------- F. F. Golden, Madison

Section on Surgery

Chairman ---------- Kenneth Lemmer, Madison
Secretary ---------- Norman Becker, Fond du Lac
Delegate ---------- G. N. Gillett, Racine
Alternate ---------- John Conway, Milwaukee

Section on Urology

President ---------- F. M. Hilpert, Racine
Vice-President ------ P. B. Brunkow, Monroe
Secretary ---------- D. W. Calvy, Milwaukee
Delegate ---------- J. W. Sargent, Milwaukee

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

Dr. John M. Dodd† ---------- 1930
Dr. Cornelius A. Harper† ---------- 1930
Dr. John J. McGovern† ---------- 1931
Dr. Louis M. Jermain† ---------- 1931
Dr. Edward Evans† ---------- 1931
Dr. Mina B. Glasier† ---------- 1932
Dr. Arthur W. Rogers† ---------- 1934
Dr. Rock Sleyster† ---------- 1934
Dr. Olin West† ---------- 1934
Edward A. Birge, Ph. D.**† ---------- 1935
Dr. Arthur J. Patek† ---------- 1935
Dr. Joseph F. Smith† ---------- 1937
Dr. Eben J. Carey† ---------- 1938
Dr. William S. Middleton ---------- 1938
Dr. Fred G. Johnson† ---------- 1939
Dr. William D. Stovall ---------- 1940
Dr. Ludvig Hektoen***† ---------- 1941
Dr. Stephen E. Gavin ---------- 1944
Dr. F. Gregory Connell ---------- 1947
Dr. E. R. Schmidt ---------- 1949
Dr. Armand J. Quick ---------- 1950
Dr. F. A. Stratton† ---------- 1951
Dr. Gunnar Gundersen ---------- 1953
W. J. Meek, Ph.D. ---------- 1953
Dr. R. G. Arveson ---------- 1957
Edwin B. Fred, Ph.D. ---------- 1958

** Then president of the University of Wisconsin and professor of zoology.

*** Centennial Award.

† Deceased.

Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac ---------- 1841–1847
J. B. Dousman, Milwaukee ---------- 1848, 1849
A. L. Castleman, Delafield ---------- 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield ---------- 1855
John Mitchell, Janesville ---------- 1856
D. Cooper Ayres, Green Bay ---------- 1857
Clark G. Pease, Janesville ---------- 1858, 1859
E. S. Carr, Madison ---------- 1860, 1861
Solomon Blood, Rochester ---------- 1862
(No meetings held from 1863 through 1866; apparently no new officers).
Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee ---------- 1870
H. P. Strong, Beloit ---------- 1871
John Favil, Madison ---------- 1872
Harmon Van Dusen, Mineral Point ---------- 1873
M. Waterhouse, Portage ---------- 1874
J. T. Reeve, Appleton ---------- 1875
J. B. Whiting, Janesville ---------- 1876
J. K. Bartlett, Milwaukee ---------- 1877
Darius Mason, Prairie du Chien ---------- 1878
Nicholas Senn, Milwaukee ---------- 1879
J. G. Meachem, Sr., Racine ---------- 1880
Ira Manley, Jr., Markesan ---------- 1881
William Meacher, Portage ---------- 1882
T. P. Russell, Oshkosh ---------- 1883
N. M. Dodson, Berlin ---------- 1884
E. W. Bartlett, Milwaukee ---------- 1885
G. M. Steele, Oshkosh ---------- 1886
S. C. Johnson, Hudson ---------- 1887
L. G. Armstrong, Boscobel ---------- 1888
J. R. Barnett, Neenah ---------- 1889
E. M. Rogers, Hartford ---------- 1890
G. D. Ladd, Milwaukee ---------- 1891
G. F. Witter, Grand Rapids, Mich. ---------- 1892
B. T. Phillips, Menominee, Mich. ---------- 1893
B. C. Brett, Green Bay ---------- 1894
Almon Clarke, Sheboygan ---------- 1895
F. W. Epley, New Richmond ---------- 1896
B. O. Reynolds, Lake Geneva ---------- 1897
William Mackie, Milwaukee ---------- 1898
Herman Reineking, Milwaukee ---------- 1899
W. T. Sarles, Sparta ---------- 1900
J. F. Pritchard, Manitowoc ---------- 1901
W. H. Neilson, Milwaukee ---------- 1902
J. V. R. Lyman, Eau Claire ---------- 1903
F. E. Walbridge, Milwaukee ---------- 1904
C. W. Oviatt, Oshkosh ---------- 1905
J. R. Currens, Two Rivers ---------- 1906
L. H. Pelton, Waupaca ---------- 1907
W. E. Ground, Superior ---------- 1908
Gilbert E. Seaman, Madison ---------- 1909
Edward Evans, La Crosse ---------- 1910
Byron M. Caples, Waukesha ---------- 1911
John M. Dodd, Ashland ---------- 1912
Arthur J. Patek, Milwaukee ---------- 1913
Charles S. Sheldon, Madison ---------- 1914
T. J. Redelings, San Diego, Cal. ---------- 1915
L. J. Jermain, Milwaukee ---------- 1916
Hoyt E. Dearholt, Milwaukee ---------- 1917
Gustave Windesheim, Kenosha ---------- 1918
D. J. Hayes, Milwaukee ---------- 1919
C. R. Bardeen, Madison ---------- 1920
H. W. Abraham, Appleton* ---------- 1921
M. A. McGarty, La Crosse ---------- 1921
S. Hall, Ripon ---------- 1922
F. G. Connell, Oshkosh ---------- 1923
Rock Sleyster, Wauwatosa ---------- 1924
Wilson Cunningham, Platteville ---------- 1925
Joseph F. Smith, Wausau ---------- 1926
Arthur W. Rogers, Oconomowoc ---------- 1927
John J. McGovern, Milwaukee ---------- 1928
Karl W. Doege, Marshfield ---------- 1929
F. J. Gaenslen, Milwaukee ---------- 1930
A. J. McDowell, Soldiers Grove** ---------- 1931
C. A. Harper, Madison ---------- 1931
Otho Fiedler, Sheboygan ---------- 1932
Reginald H. Jackson, Madison ---------- 1933
Stanley J. Seeger, Texarkana, Texas ---------- 1934
T. J. O'Leary, Superior ---------- 1935
R. M. Carter, Green Bay ---------- 1936
Stephen E. Gavin, Fond du Lac ---------- 1937
James C. Sargent, Milwaukee ---------- 1938
A. E. Rector, Appleton ---------- 1939
R. G. Arveson, Frederic ---------- 1940
R. P. Sproule, Milwaukee ---------- 1941
Gunnar Gundersen, La Crosse ---------- 1942
F. E. Butler, Menomonie ---------- 1943
R. M. Kurten, Racine ---------- 1944
Charles Fidler, Milwaukee ---------- 1945
P. R. Minahan, Green Bay ---------- 1946
C. A. Dawson, River Falls ---------- 1947
W. D. Stovall, Madison ---------- 1948
K. H. Doege, Marshfield ---------- 1949
J. W. Truitt, Milwaukee ---------- 1950
H. H. Christofferson, Colby ---------- 1951
A. H. Heidner, West Bend ---------- 1952
J. C. Griffith, Milwaukee ---------- 1953
H. Kent Tenney, Madison ---------- 1954
Arthur J. McCarey, Green Bay*** ---------- 1955
Ervin L. Bernhart, Milwaukee ---------- 1956
L. O. Simenstad, Osceola ---------- 1957
Harry E. Kasten, Beloit ---------- 1958
Jerome W. Fons, Milwaukee**** ---------- 1958

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.
*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.
**** Resigned during term of office.

THE MEDICAL FORUM

Doctor Hess and Mauston Hospital Success Story

MAUSTON—The story of the Mauston Hospital is, in a large sense, the story of its founder, the late Dr. J. S. Hess.

When he began his practice here in 1893, he found many of his patients dying of "inflammation of the bowels." Unable to halt the deaths, he returned to school for a postgraduate course in surgery. Returning to Mauston, he began to operate for peritonitis.

Dr. Hess found proper sanitation extremely difficult, for many of his operations were performed on kitchen tables. Even his office he felt was inadequate, so in 1912 he and his nurse built a hospital over what is now the Hess Clinic.

But by 1920, this too had become inadequate and Dr. Hess conceived the idea for a large modern hospital. He organized a stock company and sold shares to farmers and local businessmen, assuring them 4 per cent interest on their investment. He also put all of his life savings into the project which became a reality in 1922.

His son, Dr. J. S. Hess, Jr., joined him in practice, and took over when he suffered a heart attack in 1935. Dr. Hess Sr., died in 1937. Prior to his death, Juneau County residents staged a huge celebration in his honor and presented a plaque to the veteran practitioner, citing him for 42 years of community service and for his great effort making the hospital a reality.

Dr. Hess Sr. owned the first Ford in Mauston, and used it at a time when roads were almost non-existent. On one occasion, the car jacknifed while going over a bridge and tumbled into the water. The doctor lost everything but his life.

Later he converted one of his cars into a snowmobile, replacing the front wheels with runners and the back wheels with lug treads.

Mauston oldtimers tell you, too, of the flu epidemic in 1918, when Dr. Hess went for 30 days without removing his clothes to sleep, catching a few winks between rounds. His son says his father wore out six or seven drivers during the siege.

DR. J. S. HESS is shown standing before the steps of the old hospital structure. His offices were on the first floor. The picture was taken more than 36 years ago.

The old gentleman must have seemed indestructible until his heart attack 23 years ago. For the first time, he was forced to take things a little easier.

Dr. Hess jr. said that the advent of voluntary insurance was a major factor in making the hospital pay for itself and its improvements.

He now practices with Drs. Vernon M. Griffin, M. S. Tverberg and J. H. Vedner. They have a great tradition to follow.

Report of Council Actions At December 13–14 Meeting

Requests Copies of County Bylaws At Early Date

MADISON—Major items of medical organization and health care were acted upon at the December 13–14 meeting of the Council. Thirteen Councilors and three officers attended.

President W. B. Hildebrand, Menasha, outlined to the Council his goals for a basic program of professional and public relations. He urged continued efforts to settle current differences over insurance "without the courts and without compulsion."

He stressed the urgent need for contacts with state and federal legislators on public health matters, and he pledged a statewide effort to augment intraprofessional relations through personal appearances before county medical societies.

Among the items acted upon by the Council were:

Local option should govern the hypertension survey of the State Board of Health involving the recording of blood pressures by its mobile x-ray units. The Board was urged to use the survey method only upon invitation and approval by the county medical society.

Approval was given to the "Guide for Physicians and News Media," prepared after two years of discussions by the Council on Medical Service with representatives of eight major news media organizations. Certain portions of the guide relating to hospitals are being discussed with the Wisconsin Hospital Association. When complete the guide will be printed in booklet form and made available to physicians and news men.

(Continued on page 86)

COUNCIL . . .

(Continued from page 85)

The Council approved "in principle" a proposed legislative measure being backed by several state and voluntary agencies to authorize the charging of fees in adoption cases. Fees would be based upon ability to pay. No endorsement of specific legislation was made, pending study by the Public Policy Committee.

The report of the Commission on Medical Care Plans was presented by Doctor E. M. Dessloch, Prairie du Chien, chairman. It was reviewed in detail and accepted by the Council. Highlights are:

1. "The volume of activity caused by WPS–Blue Shield becoming its own agent, and being forced to enter into the area of hospital costs protection by refusal of Blue Cross to provide a companion plan, necessitated rapid developments of total implementation in June, 1958. On authority of the Council, your secretary and general manager secured the services of a management consultant who aids the staff in implementing certain aspects of our new operation and who has been studying our operational organization."

   Mr. Herman L. Toser, Stevens Point, for 25 years associated with Hardware Mutuals when he established his own business, has served in this capacity. Doctor Dessloch said the Commission heard Mr. Toser's report at its December meeting and "is satisfied that matters are well in hand."

   "Some procedures have been reevaluated and streamlined. Duties of the staff are being reassigned in some minor respects to produce more logical handling. The major development is the creation of an Underwriting Department along the lines generally accepted as necessary in the operation of this type of activity."
2. The Executive Committee of the Commission will be enlarged and meet monthly. Quarterly financial reports will be printed in the JOURNAL.
3. Official communications are to be forwarded promptly to the Insurance Commissioner and the national association of Blue Shield plans notifying them that the extension of Surgical Care into the state is disapproved.
4. County medical societies are reminded of the Council suggestion that they poll their memberships on the desire of members to participate in Surgical Care of Milwaukee.
5. By action of the House of Delegates on the Dane County resolution, Blue Shield in Wisconsin is directed to become "one" in the sense that both plans are under final direction of the House as to policy matters. Surgical Care of Milwaukee continues as a plan franchised to that area, and to that area alone.
6. The State Medical Society will not seek introduction of legislation regulating the "Blue" plans in the 1959 session, but will support proposals originating elsewhere if they meet certain tests. These would require annual reports, approval of all contracts, periodic examination by the Insurance Department, licensure of sales personnel, and payment of some kind of fee in lieu of taxes. Public rate control would be opposed because it would place the "Blue" plans at a competitive disadvantage with commercial companies which do not have such control on health policies, and because it would bring rates into political areas instead of leaving them as matters of professional and competitive judgment.
7. Rumor has been circulated that should WPS be unable to discharge its contract liabilities, State Medical Society members would be personally liable. The Council accepted legal counsel assuring that this was untrue.

Studies of county medical society constitutions and bylaws were discussed. Some societies have "lost" or "don't have" bylaws. Others need updating. The Council requested all counties which have not already done so to send a copy of their constitutions and bylaws to the Society office at Madison.

Beginning in January, 1959, the Executive Committee of the Council will meet monthly rather than on call.

ANNUAL MEETING

Mark your calendar now for the SMS Annual Meeting in Milwaukee on May 5, 6, and 7, 1959. Many new features have been incorporated into the program as outlined on page 26* of this issue.

Rogers Lectures Slated in State Feb. 25 and 26

MILWAUKEE—Dr. Samuel Bellet, Director, Division of Cardiology, Philadelphia General Hospital, Philadelphia, Pa., will be guest lecturer at the eighth annual Dr. Malcolm F. Rogers lectures. Sponsored by the Wisconsin Heart Association in cooperation with Marquette University and the University of Wisconsin medical schools, the lecture is scheduled for Feb. 25 and 26 in Madison and Milwaukee.

In Madison, Feb. 25, plans call for a 4 p.m. convocation for medical students. The lecture will again be given in the evening at 8:00 p.m. for physicians. The evening lecture will be given in Bardeen auditorium at the medical school.

In Milwaukee, Feb. 26, a clinic will be held in the fifth floor conference room of County General hospital at 10:00 a.m. Dr. Bellet will give his lecture at 8:00 p.m. in the Marquette University Medical School auditorium, 561 N. 15th St.

The Malcolm Rogers lectures are arranged each year with eminent physicians as guest speakers by the Wisconsin Heart Association as part of its medical education program.

A BILL OF GOODS . . .

SOCIAL SECURITY SAYS: "Your social security taxes pay for these nine programs:

Social Insurance
- (a) Unemployment insurance
- (b) Old Age and Survivors Insurance

Public assistance to the needy
- (a) Old-age assistance
- (b) Aid to the needy blind
- (c) Aid to dependent children
- (d) Aid to the permanently and totally disabled

Children's services
- (a) Maternal and child-health services
- (b) Services for crippled children
- (c) Child-welfare services

In Other Words: In spite of the fact that most of these represent federal grants to state aid, this Social Security program is being sold to you and me as "contributory social insurance."

SOCIALIZED MEDICINE HAVING ITS TROUBLES IN HUNGARY

BUDAPEST, HUNGARY—Socialized medicine is limping along in Hungary, according to a recent article written by Health Minister Frigyes Doleschall. His comments appeared in The Review of Domestic Politics.

He said the nation's Communist government is complaining about the way its system of socialized medicine is working—partly because over a third of Hungary's 10,000,000 people are still outside it.

"These people are forced to buy back their health from the doctors and in case of more serious illness, must pay for hospital treatment," Doleschall said. "In other words, they must obtain medical care in a manner that hardly differs from the one prevailing in capitalist countries."

Virtually all physicians in Hungary receive a salary from the government. Patients pay for health service in the form of social insurance fees deducted from their salaries.

The minister said there are complaints that doctors neglect their insured patients in favor of private patients who pay directly. Sometimes, he said, insured patients also pay their physicians on the side. Some doctors live as well or better than the best-paid people in Hungary.

"In practice," Doleschall summarized, "this means that the old capitalist system exists and that those who pay their doctors get far better treatment than those who go to them merely within the framework of the health insurance system."

Doleschall suggested a special code of regulations be composed, and the assistance of a doctors' ethics committee be utilized.

DOCTOR!

Have you sent in your entry for the Wisconsin Physicians' Photography Exhibit? Do so today!! Write to Box 1109, Madison 1, Wis.

Memo: New Pamphlets Due

CHICAGO—Coming up soon, three new A. M. A. pamphlets for the public:

Free Choice of Physician—telling why it is important for the patient seeking thorough and sound medical care to retain his right to select his own personal M.D.

Today's Cost of Medical Care—explaining why the public's medical fee dollar buys more and better care today than 20 years ago, despite rocketing living costs.

The "Judgment" in Medical Practice—detailing the physician's art, in addition to such tangible benefits as training, knowledge of techniques and dexterity.

The pamphlets, to be available later this fall, were planned to serve as public relations aids for the doctor. Orders will be accepted in the near future.

Close Hoxsey Clinic in East

WASHINGTON, D. C.—After a 3½ year fight, the Food and Drug Administration has succeeded in closing the door of the Hoxsey Cancer Clinic in Portage, Pa.

The administrator and directors of the clinic signed court papers recently promising to close at once, thus staving off proceedings by the F. D. A. charging criminal contempt. The agency declared that immediate closing was more in the public interest than continuation of legal proceedings.

The administration has not been able, however, to shut down Harry Hoxsey's home base cancer clinic in Dallas, Tex. It is now known as the Taylor Clinic, but Hoxsey shares profits with its osteopathic director, according to the *Washington Report on the Medical Sciences.*

The *Report* said another clinic in Los Angeles is giving the Hoxsey treatment but his financial connection, if any, with that one is not so clearly established.

A.M.E.F. Reports New Contributions

CHICAGO—Contributions totalling $3,661 were received by the American Medical Education Foundation from Wisconsin sources in recent months.

The contributions included those from 26 county medical society auxiliary groups in Wisconsin, in Barron, Brown, Crawford, Dane, Dodge, Douglas, Fond du Lac, Green Lake, Jefferson, Kenosha, Lincoln, Manitowoc, Marathon, Milwaukee, Outagamie, Pierce–St. Croix, Polk, Portage, Racine, Rock, Sauk, Sheboygan, Vernon, Washington, Waukesha and Winnebago, and from the Woman's Auxiliary to the State Medical Society of Wisconsin.

(Continued on page 89)

INCOME PROTECTION INSURANCE

provides a tax-free income when you need it most . . when you are unable to perform duties of your profession.

TIME HEALTH POLICIES

guarantee up-to-date protection specifically designed to meet your special needs

T·I·C

TIME

INSURANCE COMPANY

MILWAUKEE WISCONSIN

Here's a P-R Idea!

BINGHAMTON, N. Y.—To demonstrate Binghamton doctors' concern over all phases of their patients' medical care, the Broome County Medical Society held an ambulance inspection day recently.

Fifteen ambulances from around the county gathered in a factory parking lot to undergo an examination by representatives of the medical society, Red Cross and police officers. Each satisfactorily equipped vehicle received a certificate signed by the chairman of the society's committee on first aid and transportation of the injured.

The entire project took only a few hours, but it brought the society highly complimentary publicity in the form of newspaper stories and pictures.

Ambulance agencies were notified of inspection requirements in advance so that all but one were able to secure the proper equipment in time to pass the test. The drivers, many of whom are volunteers, received public recognition and a new awareness of the importance of their jobs.

Broome County residents were pleased to know that in an emergency they could count on proper ambulance transportation.

AMEF REPORTS CONTRIBUTIONS

CHICAGO—The American Medical Education Foundation recently reported it had received contributions from the following Wisconsin physicians:

Drs. John M. Bell, C. H. Boren, Clark H. Boren, James A. Boren, James W. Boren, Guy R. Duer, Everette Gustafson, Charles E. Koepp, Kenneth J. Moss, Alex T. Nadeau, K. G. Pinegar, and James D. Zeratsky, of Marinette;

Drs. Frederick Bunkfeldt, Jr., Charles L. Junkerman, August J. Jurishica, J. C. Peterson, H. Gladys Spear and Dexter H. Witte, Milwaukee;

Drs. Carl W. Schmidt, Waterloo; Blaine W. Claypool, Waupaca; R. G. Edwards, Kewaskum; Francis J. Gillette, Mondovi; Joseph M. Freeman, Wausau; Albion H. Heidner and A. T. Grundahl, West Bend; J. S. Hess, Jr., Mauston;

Drs. Donald L. Knutson, Waukesha; John T. Mendenhall, Ovid O. Meyer and James N. Moore, Madison; Antoine Barrette and Henry W. Haasl, Peshtigo; L. H. Graner, Coleman; R. J. Maginn and Edward M. McCormack, Niagara; Ralph B. Pelkey, Pound; Raymond J. Rogers, Oconto;

Drs. Robert A. Wood, Sheboygan; Emile G. Nadeau and George Nadeau, Green Bay; Wallace L. Nelson, Wisconsin Rapids; Elizabeth D. Proctor, Wood, and Reon H. Sanders of Stevens Point.

A contribution also was received from the A. Gundersen Medical Foundation at La Crosse.

LEGAL OPINION ON VENAPUNCTURE

MADISON—Information on the subject of venapuncture was recently requested by a member of the State Medical Society. The following information was prepared by the society's legal counsel:

In substance, inquiry has been made as to the legal aspects in Wisconsin relating to the following questions:

(1) Can an intravenous fluid or medicine be administered by a trained student or a graduate nurse when ordered by the attending physician?

(2) Must the attending physician, a resident, or an intern be physically present when a student or graduate nurse begins an intravenous procedure?

We submit our conclusions below but have attached to this letter an appendix which gives a part of the statutory and other authority which are the basis of our position. We conclude that:

1. The puncture of the skin and the entering of a blood vessel is an operative procedure, and as such falls within the definition of the practice of medicine under Wisconsin law. It can be initiated only by a physician, or on his order.

2. The practice of medicine in Wisconsin is premitted to only those licensed for that purpose under Chapter 147 of the statutes. Nurses are not so licensed.

3. An intravenous procedure is not in the category of "general nursing procedures and techniques" which a nurse may execute independent of the supervision or direction of a physician. It is rather a procedure or technique used in the treatment of the sick and as such, it is the legal responsibility of a person licensed to practice medicine and surgery.

4. Since a nurse is not licensed to practice medicine, her acts, except in emergency, must be performed under the general or special supervision or direction of a licensed physician. This principle includes intravenous administration.

5. An intern is not authorized to practice medicine or surgery under Wisconsin law, even though he has completed his formal medical education. Because he is not licensed to practice medicine and surgery, his supervision or direction is not a substitute for that of a licensed physician, including a resident. The latter must be licensed under Wisconsin law.

6. Since a licensed physician is legally and professionally responsible for an intravenous treatment which he ordered for a patient, it is a matter of professional judgment whether he is physically present and in direct supervision of the administration of an intravenous fluid or medicine. If no situation is presented by the patient or the equipment which would appear to require the exercise of professional medical judgment, and the nurse is well trained and experienced, it would appear that a physician need not remain personally present during the administration of an intravenous fluid or medicine. If there is any question of a complication, or even the reasonable likelihood of one, it seems legally advisable that the attending physician, or a resident, initiate the procedure, or be present when it is initiated, that he remain until he is satisfied that the procedure is progressing without complication, that he remain available or issue adequate instructions to cover complications which might reasonably be anticipated.

The above conclusion has reference to such special situations as the patient in shock or in a post-operative period.

SUBMISSION OF BILLS FOR SERVICES RENDERED TO ARMY MILITARY PERSONNEL BY CIVILIAN HOSPITALS, PHYSICIANS

Your Bills to Right Channel Help Processing

As a general rule, civilian medical agencies are aware of the appropriate channels for submission of their charges for care furnished Army military personnel. They are informed of the correct procedure, either by prior arrangement with the appropriate military authority for routine medical care of personnel under their jurisdiction, or through notification to the patient's Commanding Officer, or the Surgeon of the Army area in which emergency type of service is rendered.

In situations where the above does not apply or when the civilian medical agency is in doubt concerning the normal procedure, bills may be submitted directly to Headquarters Fifth US Army, Office of Army Surgeon, 1660 East Hyde Park Boulevard, Chicago 15, Illinois, with a request that they be placed in appropriate channels for settlement.

Such bills should show name, rank, service number, organization and duty station of the patient, disease or disability treated, inclusive dates and nature of the services, and a brief statement of the incident leading to the treatment.

The above pertains *only* to care of military personnel, and should *not* be confused with the established procedures for the processing of claims for care of eligible military dependents under MEDICARE.

Similar information from the Air Force was printed in the November issue of the JOURNAL.

Where'll It Go?

SOCIAL SECURITY SAYS: "There is no provision in the law which permits a refund of social security taxes paid if you do not have enough work under the law to get social security payments."

In Other Words: Your uncollectable "contribution" goes to charity, and not "insurance."

NEED FILMS? CALL S.M.S.

MADISON—The State Medical Society stands ready at all times to help county medical societies and individual physicians obtain films, film strips, slides and exhibit material.

While the society does not maintain a film library of any kind, it serves as a coordinating source for the hundreds of organizations which provide the audio and visual materials.

Ideal for county and hospital staff meetings, the aids may be obtained on almost any subject on notice of several weeks or more by writing the society at Box 1109, Madison 1.

New to the service is Exhibits-on-Film, which portray scientific displays at medical meetings throughout the nation, and helpful to physicians anxious to keep up with developments in medicine and surgery.

One new filmstrip series shows the exhibits shown at the 106th annual meeting of the A. M. A. in June, 1957.

OFFER NEW MEDICO-LEGAL FILM

MADISON—County Medical societies are invited to show a new medico-legal film, "The Men Who Didn't Walk," the third in a series produced by the American Bar Association and the A. M. A.

The subject centers around traumatic neurosis, sometimes a puzzling siutation for physicians and attorneys, and sometimes a clever device assumed by a claims-seeking plaintiff.

The film, 16-mm, sound, develops a case of alleged traumatic neurosis. Medical examination and courtroom procedure are employed to bring in areas of conflict and ways to solve points of controversy.

The State Medical Society, Box 1109, Madison 1; the A. M. A., and the State Bar of Wisconsin, 122 W. Washington avenue, Madison are making the film available without cost.

Previous pictures in the series were "The Doctor Defendant" and "The Medical Witness."

A.M.E.F. . . .

(Continued from page 87)

Other donors included:

Drs. Arnold H. Barr, Port Washington; Albert J. Baumann, R. A. Wiethaup and Robert R. Wiethaup, Milwaukee; Robert F. Boock, Beaver Dam; H. W. Christensen, Wausau; K. W. Covell, Racine; Thayer C. Davis, Beaver Dam; Jack M. Markowitz, Racine; Gordon J. Schulz, Union Grove; J. M. Freeman, Wausau; Lamont R. Schweiger, Milwaukee; George G. Stebbins, Madison and James M. Sullivan, Milwaukee.

The A. M. E. F. reported contributions from the Frederic, Wis., Clinic, the Wisconsin Society of Anesthesiologists, Benjamin Franklin School in Milwaukee, and the Milwaukee Society of Internal Medicine.

PROFESSIONAL BUSINESS SERVICE
1204 State Street
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Business Consultants to the Medical Profession.

Inquiries Invited

OUTLINE ADVANTAGES OF FREE ENTERPRISE SYSTEM

By D. HERSCHEL MILLS

ANGLETON, TEX.—The greatest monument I have ever seen to free enterprise is the modern American supermarket. On a single shelf may be found one product under fifteen different labels, every one of those labels proclaiming its product to be the best made. Fifteen manufacturers, each trying to convince the public that only he can produce green peas capable of satisfying hunger! This is free enterprise!

What is free enterprise? It is a steel mill in Pittsburgh, an oil well in Texas, an orange grove in Florida. It is a man wiping the sweat from his brow in the corn field of Iowa, a doctor preparing for surgery. It is a one-room schoolhouse in the mountains of Kentucky. It is a wadded section of the stock market reports from a morning newspaper and, yes, it is the grin on a little boy's face as he tries to sell lemonade. "Only a nickel, mister." That's free enterprise. That's why our forefathers died. And it's what we must live for.

Many denounce this system by which man earns according to his desires and capabilities. But they would destroy man's ambition, making him a robot with no incentive for advancement. What a flimsy, weak-willed creature man would be!

The main advantage of socialism, according to its staunchest advocates, is the security it provides. Under socialism, they say, poverty could be destroyed and man could live in peace, assured that no twist of fate could force him down into the gutters of life and prevent his rise. All would be equal, the socialists claim, despite their intelligence, ambition and initiative. The drunken bum could be placed on the same level with the most distinquished statesman This, they say is security.

This may really be security. But while security may be one of the most universally pursued goals, it is also one of the most universally deceptive goals. Few would actually want security if they got it. There is something about sweat and toil and tears that appeals to man's soul. To be deprived of the right to advance would tear man away from himself.

Man is a competitive being. All progress, whether intentional or not, has been derived from this competition. When man betters himself, he often betters humanity. Competition also provides better qualities. The man who must produce a better product than his neighbor will naturally produce a better product than someone who is not subjected to these pressures. The truth of the statement can be proved by comparing an American car and a Russian car. The American car is ahead by at least ten years in all respects. Nowhere, except in a free enterprise system, can man progress so far in so short a time as he has progressed in 20th century America.

This brings us to another important point, democracy. To bring us democracy, to bring us freedom, our ancestors lived and worked and fought. The blood of America's sons was shed on Bunker Hill, at Gettysburg, at the Marne river, at Iwo Jima, Normandy and Porkchop Ridge, shed so that the light of democracy might shine on our land forever. Our common heritage of democracy makes us all zealous in protecting that democracy.

And what could be more democratic than free enterprise? What could be freer than for a man to earn his bread by the sweat of his brow? Abraham Lincoln referred to this nation as a nation "of the people, by the people, for the people." But how can a nation be "of the people" and deny the right of private ownership of property? How can a nation be "by the people" if it thwarts individual initiative? And how can a nation be "for the people" if it restricts individual opportunity for advancement? Freedom is impossible without a system of free enterprise.

One of the biggest advantages of the free enterprise system is that it permits private ownership of property and business. We all know that a man will take more pride in something he owns than he will in something owned by somebody else. The destruction of an individual's right to own property also destroys his ability to achieve, curbs his initiative and decreases his productivity and usefulness. Free enterprise is necessary for man to perform to the best of his capabilities.

NOTE!

This essay won $1,000 for D. Herschel Mills, a high school senior of Angleton, Tex. The contest was sponsored for the 12th year by the Association of American Physicians and Surgeons Inc., in cooperation with state and county medical societies.

Young Mills told the association he owes a great deal to the medical profession, saying:

"When I was born, a Ceasarian operation saved my mother's life. As a result, I was named for the doctor who performed the operation, Dr. Herschel Spurlock. Later, my life was once more endangered by a shortage of calcium in my body combined with an ear infection. Once more the skill of a doctor pulled me through."

To see in its proper perspective the difference between a country that has a system of free enterprise and one that does not we must compare the United States with the Soviet Union. The U. S. has been one of the most prosperous nations in the world. The Soviet Union has been referred to as the "world's biggest poorhouse." The American free enterprise system has produced better than an average of seven times as much coal per worker as the Soviet Union. Opponents of free enterprise say that socialism, communism, and all the "isms" created to destroy mankind would eliminate proverty and tend to build up the standard of living among the masses. Yet the average Russian worker must labor five and a half times as long as the average American worker to earn his daily bread. Without free enterprise not poverty, but prosperity, is eliminated.

Technical ability under any other system besides free enterprise would be practically non-existent. What would be the use of obtaining an education? What would be the use in gaining technical skills? The unskilled, the uneducated would all earn as much as the most highly trained and highly educated men a nation could produce. The genius could accomplish no more than an

(Continued on page 92)

WHAT IS CO-INSURANCE?

Mr. Smith buys a store building for $20,000 upon which he orders insurance from his agent. The agent says the premium on $20,000 insurance on the building will be $150 a year, but that if Smith will accept a policy containing a *co-insurance clause*—that is, a clause under which Smith agrees at all times to keep the building insured for at least 80 per cent of its value, his premium will only be $85 a year. Smith jumps at this chance to save $65 a year and accepts such a policy in the amount of $16,000, or 80 per cent of the value of the building.

Two years later, business having been very good, he decides to modernize his building, puts a new marble front on it which, with other improvements, causes his building to be now reasonably worth $30,000. Smith forgets to increase his insurance and his building is partially destroyed by fire to the extent of $5,000. He then remembers that his policy had a co-insurance clause but consoles himself by saying, "Well, as long as my loss is less than $16,000, I can collect the full $5,000." He is wrong.

His building, being worth $30,000, his policy required him to have 80 per cent or $24,000 insurance in force. Therefore, he can only collect his loss according to the proportion which the amount of insurance he actually had in force bears to the amount of insurance he should have had. The formula stated in fraction fashion is:

$$\frac{\text{Insurance carried}}{\text{Insurance required}} \text{X amount of loss} = \text{amount Smith will collect}$$

on $5,000 loss. Substituting the actual figures in place of these designations, we have:

$$\text{X } \$5{,}000 = \$3{,}333.33, \frac{\$16{,}000}{\$24{,}000}$$

which is all that he can recover under his policy from the insurance company. It means he suffered an out-of-pocket loss because of the fire over his insurance in the amount of $1,666.67.

Unless an owner is very careful to keep his insurance up to the required amount, a policy containing a co-insurance clause can prove to cost more than it saves.

EDITOR'S NOTE!

Periodically the State Bar of Wisconsin prepares a legal column as a public service, for publication in Wisconsin newspapers and publications. The column is offered to inform, not to advise, because certain facts may change the application of the law.

So that physicians of the state can study this material, the State Medical Society reprints the column on Co-Insurance.

Social Security Film Available

NEW YORK, N. Y.—A new film on social security, "A Matter of Choice," has been produced by the U. S. Chamber of Commerce.

In the light of the Forand Bill situation, the film is a particularly timely illustration of the A. M. A. point of view. The 26-minute film clarifies the original purpose of the system as Congress intended it, and shows the dangers of making it a political football—with benefits boosted every election year.

County medical societies or other M. D. groups interested in showing the film may make reservations by writing to the State Medical Society of Wisconsin, Box 1109, Madison 1, or to the Modern Talking Picture Service Inc., 3 East 54th St., New York 22, N.Y. The film is 16-mm and available at no cost.

Society Pushes Civic Activity

ATLANTA, GA.—If Atlanta physicians are getting a reputation for civic spirit, it's no accident.

The Fulton County Medical Society's citizenship committee doesn't leave physician participation in community service to chance. First the committee found out the needs of various local organizations, then sent out postcards to all members asking them to volunteer their services. Seventy-three members responded.

Then the committee surveyed society members to learn what activities they were engaged in. Of the 43 per cent who replied, each averaged four civic activities. Church work drew 89 per cent of the physicians, but members also were active in youth groups, PTA, civil defense organizations, Chamber of Commerce, service clubs, health and welfare agencies and even UN and international groups

Each month the society bulletin lists the names of members participating in different types of community service so that others who are interested will know whom to contact. Each year the group presents a citizenship award to the doctor who makes the most outstanding contribution in the area of public service.

STANLEY, WIS.—This community's new clinic building, which was dedicated last fall, was described by the local newspaper, the *Stanley Republican*, as "a credit to our city and the result of a dream come true for our doctors." The physicians are Dr. A. W. Overgard, who came here in 1932, and Dr. R. J. Mathwig, who joined him in 1946.

An L-shaped structure, the building is constructed of redwood and brick. It houses, all on one floor, a waiting room, hallway, two large consultation rooms, several small examination areas, an emergency room, main business office, laboratory, treatment room, x-ray room and a dark room. *(Photo by Doniels, of the Republican)*

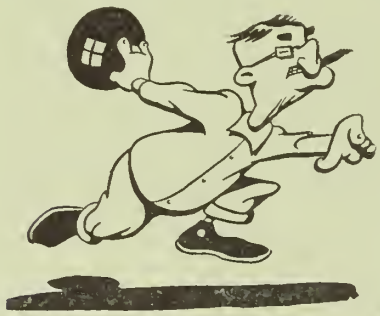
BOWLING TOURNAMENT STARTS FEB. 7 AT MADISON

Third Annual Event For Physicians

MADISON—More than 90 physicians and wives from all parts of Wisconsin will convene in Madison on Saturday, Feb. 7, to splatter the pins at the Bowl-A-Vard Lanes in the third annual Wisconsin Physicians' Bowling Tournament. Bowling will start on the twenty alleys at 9:30 in the morning with mixed doubles. Following lunch the men's singles, men's doubles, men's team event and the auxiliary singles championship will be rolled off in two classes.

Participants will wind up the day with a social hour and dinner at the Edgewater Hotel.

Beautiful trophies await the top winners. Non-participating physicians are also welcome to watch the event and lend moral support to their colleagues. A big day of fun in Madison—Feb. 7!



SUPERIOR—Joined together for dinner during the postgraduate circuit program here last fall were five participants and a host, Dr. Victor Ekblad (second from right). The others (left to right) were: Dr. Malcom McCannel, of the University of Minnesota Medical School; Dr. Herman H. Shapiro and Dr. Ben M. Peckham, of the Wisconsin Medical School; Dr. George E. Collentine, Jr. and Dr. Timothy R. Murphy, Marquette University School of Medicine.—*(Superior Telegram photo)*

ON THE S.M.S. CALENDAR

FEBRUARY

- 4—Claims Committee, S.M.S.
- 5—Meeting on Maternity Standards (State Board of Health)
- 7—Wisconsin Physicians' Bowling Tournament
- 9–11—Blue Shield Medical Care Plans Public Relations Conference, Chicago.
- 28—Annual Meeting of Council

MARCH

- 1—Annual Meeting of Council
- 5–7—A.M.A. Rural Health Conference, Wichita, Kan.
- 12—Wisconsin Hospital Association Annual Meeting

Union Wins Dental Insurance Coverage

NEW YORK—Dental insurance benefits were won for the Oil, Chemical and Atomic Workers, Local 14–149 of New York City, in what the union claims to be the first non-profit dental insurance program attained through collective bargaining.

The union president termed it "a break-through comparable to that of 1946 when unions began to bargain for hospital and medical care . . . This heralds a trend of collective bargaining for dental benefits to complete the health care package."

Under the plan, members may select their own dentists. Over 4,100 dentists in metropolitan New York City reported to be participating dentists of Group Health Dental Insurance agreed to accept its allowances as full payment for subscribers whose annual family incomes are $5,000 or less.

According to the *Health and Welfare Newsletter* of October, 1958, the plan provides "standard dental benefits" and a "rider which gives union members the full contract allowance for fillings and extractions which are needed at the first dental checkup."

MILLS . . .

(Continued from page 90)

idiot! The college professor would be no more than an illiterate bum. Invention would reach a standstill. Scientific advancement would be thwarted. Production would be slowed to a snail's pace. There would be no dreams, only drudgery. How could man progress in such a stagnant atmosphere?

Free enterprise is the world's backbone. Ludwig Erhard, West German minister of economies credited with the success of the German economy, has said, "Where there is a free market, there are sound currencies." The most industrious man is the man with highest goal in sight, a goal that will lead him higher and make him better. The most perfect position for the head is tilted upward looking at the sky and all those who have advanced the human race, regardless of the political system under which they labored, were laboring under an economic system of free enterprise which encouraged individual initiative.

DOCTOR!

Urge your patients to listen to the MARCH OF MEDICINE weekly radio program. FIFTY-TWO STATIONS!

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(continued on next page)

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Prenatal Facts

SUGGESTED PROCEDURE } **File at hospital in last month of pregnancy. If there are indications of possible premature delivery file earlier. Direct this form to the supervisor of obstetrics of the hospital to which the patient will be admitted.**

Name _____ **Address** _____ **igion** _____
Expected date of confinement _____ -- **Para** _____
Number of abortions _____ **miscarria** **del.** _____
multiple birt
Nat
Weig
Speci
Chest
Evaluati
Wasserma
Coombs te
Date of visi
Weight
Heart

FOR YOUR CONVENIENCE, DOCTOR . . .

The Division on Maternal and Child Welfare has prepared a sheet which is recommended for use by all Wisconsin physicians in reference to hospital care of obstetrical patients . . .

You will find this of convenience to you, and of much value to your obstetrical patients. It will alert the hospital to proper care when your patient is admitted for delivery.

Per pad of 100 forms—$2.00.

Write:
DIVISION ON MATERNAL AND CHILD WELFARE
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

STATE MEDICAL SOCIETY OF WISCONSIN
MEDICINA NUSQUAM NON EST

THE WISCONSIN MEDICAL JOURNAL

Volume 58 FEBRUARY 1959 Number 2

Foreign Wooden Body Present in the Buttock for Five Years*

By A. P. ZLATNIK, M. D., F. A. C. S., S. L. WELD, M. D.
Two Rivers, Wisconsin

SYDNEY S. SCHOCHET, JR., B. S., and SYDNEY S. SCHOCHET, M. D.
Manitowoc, Wisconsin

ON AUGUST 10, 1957, a 32-year-old white male patient was admitted to the hospital with a persistently draining sinus tract in the buttocks. Five years previously this man had been hit in the buttock with a piece of waste hardwood. At that time the wound was probed but no foreign body was found. The patient was asymptomatic until February, 1957, when a mass in the region of the old wound developed. At that time the area was incised but again no foreign body was found. Subsequent to this operation a sinus tract developed that thereafter drained persistently.

The patient was readmitted to the hospital on August 10, 1957. At this time the sinus tract was injected with methylene blue, and the sinus tract and adjacent scar tissue were excised along with the contained foreign body (fig. 1).

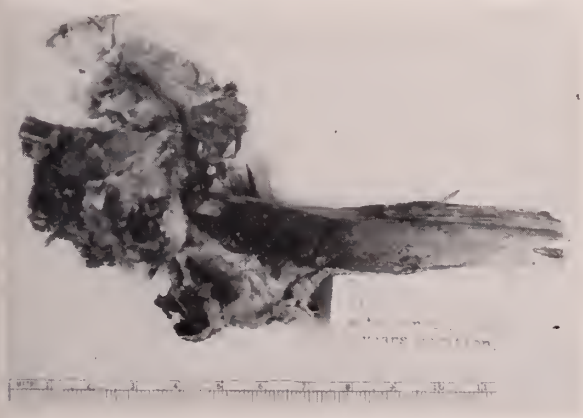

Fig. 1—Fistulous tract of buttock with foreign body, 5 years duration.

The pathologist reported that a large piece of hardwood measuring 9 x 2 x 0.9 cm. was found in the sinus tract; the walls of the sinus tract consisted of dense fibrous connective tissue with a chronic granulomatous inflammation.

The patient had an uneventful postoperative recovery after the removal of this foreign body.

Comments

This case demonstrates the minor reaction of the tissues of the body to a foreign body of this nature. The draining sinus tract is characteristic of an incompletely encapsulated object. An important corollary to cases of this nature is the need for administration of tetanus toxoid, inasmuch as tetanus can be contracted from long-buried objects as they are brought through the fresh wound caused by their removal.

The apparent nonresponse of the tissues to wood of this type may suggest the feasibility of its use as a bone splint.

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Awards for Manuscripts on Obstetrics and Gynecology

The Division of Obstetrics and Gynecology of the International College of Surgeons announced its second annual competition for two awards for the best manuscripts on a phase of obstetrics and gynecology. The first award will be $500 and the second $300.

The contest is limited to (1) interns, residents, or graduate students in obstetrics and gynecology, or (2) to those engaged in the practice or teaching of the specialty. Contestants must hold a degree of medicine from an accredited college of medicine. Fellows of the International College of Surgeons are not eligible.

Manuscripts of not more than 5,000 words must be submitted on or before June 1, 1959, to Dr. Harvey A. Gollin, secretary of the prize committee, 55 East Washington Street, Chicago, 2, Illinois. For information on contest rules, write to Doctor Gollin.

"The purpose of this contest is to advance the art and science of obstetrics and gynecology in accordance with the principles of the International College of Surgeons and with the primary aim of the College to extend the frontiers and elevate the standards of all branches of surgery," it was announced by Dr. August H. Daro, Chicago, secretary of the Division of Obstetrics and Gynecology.

PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Box 1109, Madison 1, Wisconsin.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11 with one inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wis. Med. J. 54:717–719 (Dec.) 1954.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

The Clinical Characteristics of Some Tumors of the Skin*

By HAROLD O. PERRY, M. D.**
Rochester, Minnesota

THE MORPHOLOGY of tumors of the skin enables the clinician, in most instances, to decide whether a given tumor is benign or possibly malignant. Confusion may arise in the specific diagnosis of the tumor, however, as the morphologic characteristics of one type may duplicate in detail the characteristics of another. This occurs not infrequently when cutaneous metastatic lesions of the skin mimic benign tumors of the skin. In the examination of all possibly malignant skin tumors, it should be the physician's routine procedure to advise immediate biopsy for microscopic study of the tissue.

Frequently histopathologic study of skin tumors is rewarding. Such study may confirm the benignity of a lesion and thus permit the physician to reassure the patient, or it may afford a diagnosis wholly unsuspected from the clinical examination. The most important possibility, however, is the discovery of otherwise unrecognized malignancy. In most instances the histopathology permits classification of a tumor on the basis of the type of tissue from which it originates, although there may be a difference of opinion among pathologists as to the exact histogenesis.

This occasion does not permit delineation of all types of tumors of the skin; some can be listed only (Table 1). The choice for the fuller discussion was based on the relative frequency of incidence; but if the tumor—even though encountered infrequently—is potentially malignant, mention is made of that feature. The large group of tumors of the reticuloendothelial system is omitted from discussion because the voluminous material proceeding from their involvement of multiple organs is more appropriate for separate presentation.

In discussing the types selected for more attention, I will give a few salient features

TABLE 1—*Classification of Tumors of the Skin**

I. Epidermis.
   A. Benign (epithelial nevus, junctional nevus, seborrheic keratosis).
   B. Precancerous (actinic keratosis, cornu cutaneum, arsenical keratosis, leukoplakia buccalis and vulvae, Bowen's disease, erythroplasia of Queyrat).
   C. Malignant (basal cell epithelioma, squamous cell epithelioma, malignant melanoma, Paget's disease).
II. Dermis (benign and malignant tumors may arise from any of the tissue anlage).
   A. Nevi (dermal compound, and blue nevi).
   B. Tumors of blood vessels (lymphangioma, hemangioma, hemangio-endothelioma, glomus tumor, Kaposi's sarcoma).
   C. Tumors of fibrous tissue (nodular subepidermal fibroma, fibrosarcoma, dermatofibrosarcoma protuberans).
   D. Tumors of muscle (leiomyoma cutis, granular cell myoblastoma).
   E. Tumors of nerve tissue (neurinoma, neurofibroma).
   F. Tumors of hematogenous tissue and reticuloendothelial system.
   G. Tumors of appendages.
      1. Sweat glands (syringoma).
      2. Sebaceous glands (adenoma sebaceum).
      3. Hair (trichoepithelioma, cylindroma).
   H. Tumors of fat.
   I. Metastatic tumors (distant metastases and carcinoma en cuirasse).

*With modification from Allen, A. C.: The skin; a clinicopathologic treatise, St. Louis, C. V. Mosby Company, 1954, p. 702.

*Read at the meeting of the La Crosse County Medical Society, La Crosse, Wisconsin, February 17, 1958.

**From the Section of Dermatology, Mayo Clinic and Mayo Foundation. (The Mayo Foundation, Rochester, Minnesota, is a part of the Graduate School of the University of Minnesota.)

of each which help in their clinical differentiation. Histologic differentiation will be mentioned when such seems applicable. Additional information on both clinical appearance and histopathology may be gained from standard texts on dermatology.[1-3] The consideration of individual types will follow the outline provided in Table 1, a classification not intended to be comprehensive but merely to give direction to the discussion.

Tumors of the Epidermis

Benign Epidermal Tumors: The benign tumors of the epidermis include epithelial nevus, junctional nevus, and seborrheic keratosis. The term "nevus" in its most inclusive meaning refers to any cutaneous new growths of congenital origin. Thus in the past there were references to vascular nevi, pigmented nevi, and epithelial nevi, regardless of tissue origin. In its strictest sense, a nevus includes only those tumors in which nevus cells are present. I shall use "epithelial nevus" to refer to a lesion which is present at birth or develops soon after, and contains only epithelial cells but does not contain ordinary nevus cells. Essentially it is a hamartoma, or tumor formed by overdevelopment of tissue ordinarily found in that location. But except in the phrase "epithelial nevus," the term "nevus" will indicate a lesion containing nevus cells.

Epithelial nevi take the form of warty excrescences, and are asymptomatic except when located on pressure areas of the hands or feet or in sites where they interfere with usual function of the part. Clinically, their course is benign and the individual lesion resembles an ordinary verruca vulgaris (wart). Groups of these lesions may be distributed over large areas of the body, hands, feet, face, and neck, with the individual lesions retaining their identity. Depending upon the particular distribution pattern and histology, epithelial nevi in these instances have been referred to as hard nevus of Unna, epidermodysplasia verruciformis, or acrokeratosis verruciformis.

At times the lesions are not discrete but rather lose their identity in a streak of epithelial hyperplasia, either straight or in whorls. Thus linear nevi are developed. The psychiatric repercussions caused by the unpleasing appearance of linear nevi are profound. In selected cases, plastic surgery is sometimes of benefit.

The *junctional nevus* (and in this instance I wish to indicate that nevus cells are present) is perhaps as common as any of the skin tumors encountered. Being a flat, pigmented lesion, it hardly can be classified under the term "tumor"; but a brief discussion is justified because of its role in the problem of melanoma. It is now generally accepted that nevus cells arise from the neural crest and migrate during fetal life to the epidermis. Whether the nevus cells remain localized wholly to the epidermis or the adjacent papillary bodies or both, or alternatively migrate later from the epidermis to the dermis, gives the basis for the clinical differentiation of the flat, pigmented nevus (junctional nevus) and the dermal nevus (to be described later).

Clinically, malignant melanoma arises more frequently from the junctional nevus than from the dermal nevus. Therefore it has been my practice to excise junctional nevi located at sites of frequent trauma and irritation. In addition, junctional nevi that are growing, showing increased pigmentation, or bleeding on minimal trauma are excised. Thus the patient receives the benefit of any clinical doubt in such transitional lesions. The histologic differentiation of an actively growing nevus and an early melanoma is difficult at best and is further complicated when the problem arises in prepuberal children (so-called juvenile melanoma).[4]

Seborrheic keratosis (verruca senilis, basal cell papilloma) is a common development on the face and trunk of patients in the middle and later decades of life. The lesions appear as variously sized, flat, verrucous papules which vary in color from brown to black. In the latter circumstance the differentiation from pigmented basal cell epithelioma and melanoma is a point of clinical confusion. The definite verrucous quality of the lesions and their characteristic appearance of being "stuck on" to the skin make the clinical diagnosis possible in most instances. Seborrheic keratosis is a benign lesion. Most often the patient wishes the lesions removed for cosmetic reasons; and this can be accomplished satisfactorily by electrodesiccation, in multiple stages if necessary.

Precancerous Dermatoses: In the table seven distinct entities are included among the precancerous dermatoses. Logically, Bowen's disease and erythroplasia of Queyrat might be excluded from the group, inasmuch as

they represent in their strictest sense the presence of squamous cell carcinoma in situ; but for conformity with classifications established in the past, these latter two entities will be discussed within this category.

Actinic keratosis is a localized hyperkeratotic reaction of the skin. The lesions may vary from light brown to black; they are multiple, and affect the exposed areas of the body, namely the face, the neck, and the dorsa of the hands and forearms. Their location in the exposed areas implies that physical elements—sunlight, wind, and temperature—play some definite role in their production. In addition, heredity is a factor to be reckoned with, as they are seen most frequently in persons of Northern European, Scotch, English, and Irish extraction.

In most instances these small hyperkeratotic lesions cause no local discomfort and their removal is requested only for cosmetic reasons. But those which develop a hyperkeratotic reaction that cannot be removed easily by the daily application of an emollient, those that ulcerate, and those that are accompanied by a surrounding inflammatory reaction may be in the process of becoming squamous cell epitheliomas. These are the criteria I employ in deciding whether removal by fulguration is indicated.

Cornu cutaneum is essentially a localized actinic keratosis whose adherent crust assumes a curled and twisted configuration, much like a cornucopia. The clinical evaluation of a cornu cutaneum is made in the same manner as that of an actinic keratosis.

It has been recognized that ingestion of inorganic arsenic will be followed in a certain proportion by the development of *arsenical keratosis* of the palms and soles. Arsenic has long been employed by dermatologists against various skin diseases and by physicians in general practice against gastrointestinal disturbances and asthma. Arsenical keratosis at first is characterized by the presence of translucent, hard papules of the palms and soles; but with the passage of time a verrucous element supervenes which gives the individual lesions a dirty, ragged appearance. Hyperpigmentation of the skin may at times be associated with the keratosis of the palms and soles. Epitheliomas, both basal cell and squamous cell, may be associated in a smaller proportion of cases. The epitheliomas may appear on any part of the skin, even areas distant from the keratosis of the palms and soles. The treatment for these epitheliomas in no way differs from treatment for those originating independently of ingestion of arsenic.

Leukoplakia buccalis is seen predominantly in men, less than five per cent of the cases affecting women. It consists of hyperkeratinization of the epithelium which gives a whitish sheen to the mucous membranes of the buccal mucosa, gums, and tongue. The element of trauma in the production of this condition is not to be overlooked. Ill-fitting dentures and the smoking and chewing of tobacco, as well as the presence of some infections—for example, syphilis with secondary interstitial glossitis—are known to be factors.

Leukoplakia vulvae is evidenced by the same white sheen in the tissues of the female genitalia as is seen in the mouths of the aforementioned male patients. Kraurosis is considered an independent disease, although leukoplakia and kraurosis may be associated. The most common sites of leukoplakial involvement of the female genitalia are the inner labia, perineum, and the area about the clitoris and vaginal introitus.

Leukoplakial tissue may undergo malignant degeneration at any time. Clinically this change is recognized by the presence of marked induration of the patches of leukoplakia, the persistence of fissures and cracks, and the presence of ulcers which will not heal. When any of these conditions occurs, a biopsy is required to rule out the possibility of malignant transformation.

Bowen's disease is a rare condition in which a single patch or plaque of lenticular papules is situated on the glabrous skin. Histologically the picture is that of a squamous cell epithelioma in situ. It is important to recognize that these lesions may eventuate in invasive squamous cell epithelioma which metastasizes and eventually causes death.

The other rare disease of this group is *erythroplasia of Queyrat*, which consists of a red velvety plaque that appears moist on inspection but is dry on palpation. The most common sites of involvement are the glans, prepuce, and shaft of the penis. The female genitalia and oral mucosa may be similarly affected, although this is of less frequent occurrence. Zoon[5] refers to a benign form of erythroplasia of Queyrat as "balanoposthitis chronica circumscripta plasmacellularis," the histologic examination showing an infiltration by plasma cells; and it may be that this is an entity to be distinguished.

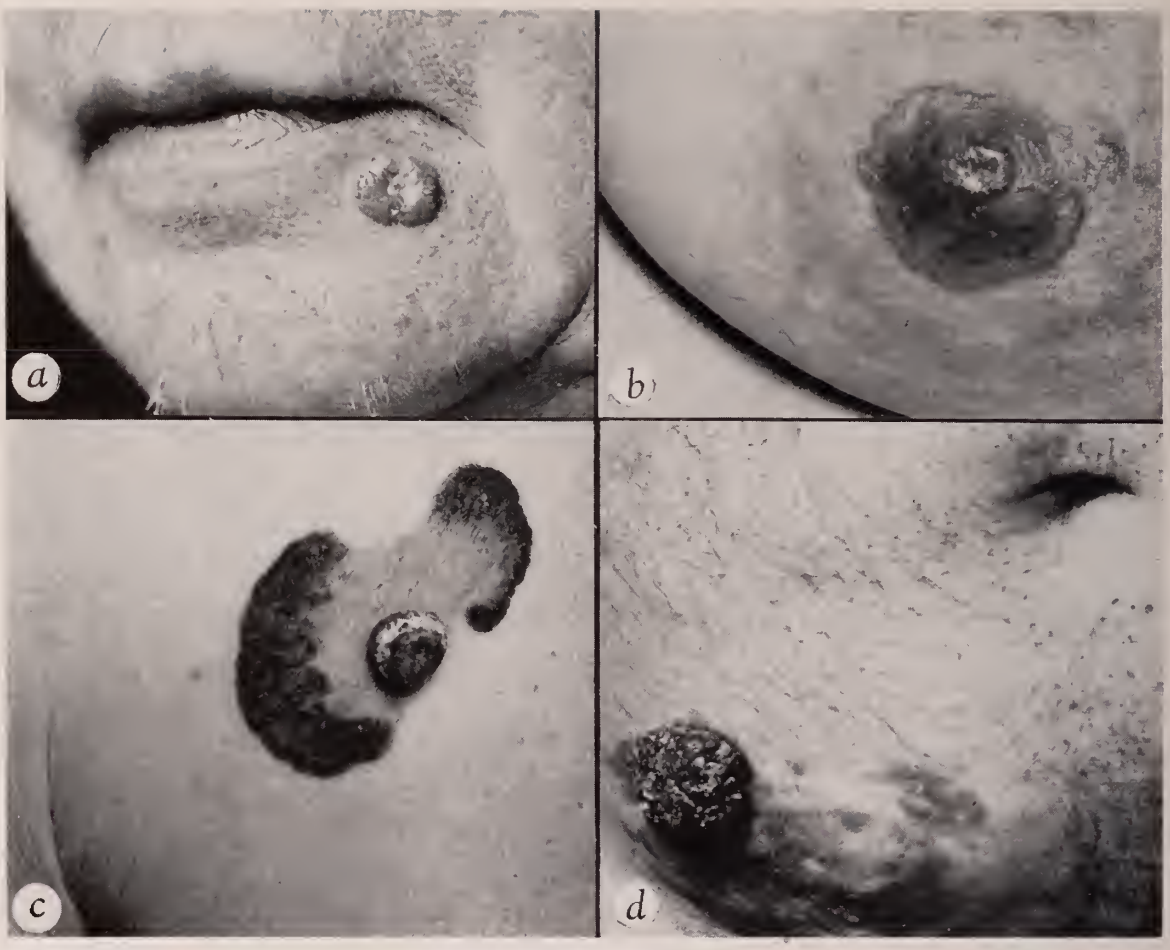

Fig. 1—Malignant lesions of the skin. (a) Basal cell epithelioma, characterized by its translucent rolled border, telangiectasia, and central ulceration. (b) Paget's disease of the breast, with the sharply marginated eczematoid reaction around the nipple which is associated invariably with an underlying ductal carcinoma. (c) Malignant melanoma, left shoulder, demonstrating the black pigmentation usually present with this tumor. (d) Dermatofibrosarcoma protuberans, presenting as a pedunculated lesion astride a plaque of conglomerate reddish-blue nodules.

Malignant Lesions of the Epidermis: Probably the commonest malignant tumor of the epidermis is the *basal cell epithelioma* (fig. 1a). At their onset these lesions consist of discrete, translucent papules or plaques. As the cancer increases in size, the margins become rolled and smooth, with the center somewhat depressed; telangiectases may course over the surface of the lesion; and ulceration may be present. This carcinoma is considered to originate from the basal cells of the epidermis. Although a malignant lesion, it does not metastasize. If distant metastasis does occur, the original lesion probably is a basal squamous cell epithelioma. Local destruction by electrosurgery, roentgen therapy, or excision is sufficient treatment for basal cell epithelioma.

Squamous cell epithelioma does not present a typical clinical picture; the lesions vary, simulating on one occasion a wart, on another a granuloma, and on still others a nonspecific ulceration. For this reason it is important to biopsy lesions which do not match any typical picture of the known skin tumors. Only thus may this entire group of malignant skin lesions be recognized. It is well to keep in mind that the biopsy of the squamous cell epithelioma in no way promotes metastasis from it.

Malignant melanoma has been discussed to some degree in relationship with junctional nevi. It appears in a variety of clinical forms, varying from a macular lesion such as a junctional nevus to papular and verrucous lesions, such as pyogenic granuloma, seborrheic keratosis, or pigmented basal cell epithelioma (fig. 1c). Should the presence of a melanoma be suspected, it is well to prepare the patient for major operation and perform all necessary operative procedures at one session. In this way one avoids the possibil-

ity of disseminating melanoma cells by performing a biopsy prior to definitive treatment.

When either a female or a male patient presents with an eczema about one nipple, the possibility of *Paget's disease* must be investigated. Paget's disease of the nipple is characterized by a wet or dry eczematoid reaction about the nipple areola which is sharply demarcated from the uninvolved skin (fig. 1b). There is no gradual fading of the reaction into the normal tissue. The clinical significance of this disease is the almost certain presence of a carcinoma of the mammary ducts. Controversy still exists as to whether the Paget cells seen histologically originate from the epidermis or whether they represent the migration from the underlying carcinoma. Be that as it may, the proper management of the case consists of a concentrated effort to locate a malignancy of that breast. Simple or radical mastectomies are done, depending on whether axillary nodes are involved.

Tumors of the Dermis

Nevi: In contrast to the junctional nevi previously described, *dermal nevi,* in which nevus cells are deep within the corium, rarely if ever give rise to malignant melanoma. It is well, however, to treat such lesions suspiciously if there is recent growth, increase of pigmentation, or spontaneous bleeding. Dermal nevi are the tumors—soft or firm, pedunculated or sessile, varying from flesh color to almost black—which are referred to clinically as "moles."

Blue nevi present a distinct clinical picture. Usually a single blue–black, well-demarcated, flat papule, 2 to 4 mm. in diameter, is seen on an extremity or on the face. The lesion occurs somewhat more frequently in the female patient than in the male. The blue–black color is characteristic, as is the history of presence for many years without apparent change. The depth of the melanocytes within the corium accounts for the deep blue color of the lesions. Blue nevi rarely become malignant and removal of them is optional.

Tumors of Blood Vessels: *Lymphangioma* is a circumscribed elastic tumor sometimes not visible as such on the skin but perceived as fusiform swelling of the tissue. As a new growth, lymphangioma is to be distinguished from lymphangiectasis, which is a dilatation of existing lymph vessels caused by mechanical obstruction. Large lymphangiomas, clinically referred to as "hygromas," are not difficult to distinguish clinically.

Special forms of lymphangioma referred to as lymphangioma circumscripta consist of groups of dilated lymph vessels whose appearance has been likened to that of frog spawn. A hemangiomatous element may be associated with this kind of lymphangioma. The lesions of lymphangioma circumscripta commonly occur first about the base of the tongue, and because of their early appearance they are considered by some to be hamartomas.

Hemangiomas have been classified clinically as port-wine stains, strawberry nevi, and cavernous hemangiomas. It has long been recognized that little can be accomplished in the way of treatment for the so-called port-wine stain. One must, however, be aware of the significance of a port-wine stain as a part of the Sturge–Weber syndrome,[6] in which a port-wine stain present in the distribution of one or all of the branches of the trigeminal nerve is associated with a pial nevus, glaucoma of the involved eye, ipsilateral calcification within the cerebrum, contralateral hemiplegia, and convulsive seizures.

Strawberry hemangiomas have been subjected to considerable treatment in the past. More recent evidence indicates that many of these lesions disappear spontaneously in the first 2 years of life. Conservative management is the holding in abeyance the use of roentgen and radium therapy and of freezing with carbon dioxide snow until ample time has been allowed for spontaneous involution to occur, if it will.[7-9]

Cavernous hemangioma, on the other hand, requires surgical intervention to destroy the more deeply situated arteriovenous anastomosis and thus eradicate the lesion.

Hemangioendothelioma is an angioma that has a malignant tendency. Its clinical characteristics are not specific, but it is a vascular mass varying from a few millimeters to several centimeters in diameter, soft to palpation, and asymptomatic. Because of frequent ulceration, these lesions tend to hemorrhage. They may be situated anywhere on the body and are more common in children than in adults. The treatment of choice is wide surgical excision. Although the prognosis in re-

spect to survival is good, local recurrence of such lesions is common.

A *glomus tumor* might easily be confused with a benign blue nevus because it is likely to be a single, well-circumscribed, blue to purplish lesion located on an extremity or under a nail. The similarity to blue nevus is apparent. The individual tumor can be soft or firm to palpation; although not spontaneously painful it is tender to touch. A decrease in temperature has been noted to cause pain in these lesions. The glomus tumor is a benign lesion, and the annoying symptom of pain upon pressure can be relieved by simple surgical excision. To be considered in differential diagnosis are neuroma (because of the pain attending that lesion), the blue nevus previously mentioned, nodular subepidermal fibrosis, and melanoma.

Kaposi's hemorrhagic sarcoma is another of the tumors of vascular origin. This disease is characterized by the presence of variously sized blue to purple tumors which occur most frequently on the lower extremities, sometimes on the trunk and upper extremities, and in the oral pharynx. When the individual lesions arise close to the lymphatics they may cause lymphatic obstruction, with edema of the extremities a common accompaniment. Ninety per cent of the patients involved are males, and they have been noted as stemming from areas in northern Italy, Poland, and Russia. The course of the disease is slow, lasting many years; and roentgen irradiation offers good control of it.

Tumors of Fibrous Tissue Origin: Of common occurrence is *nodular subepidermal fibroma,* which has been called "histiocytoma," "fibroma," "sclerosing hemangioma," or "dermatofibroma." This lesion usually occurs singly as a firm nodule, flesh-color to deep brown, adherent to the skin but freely movable over the underlying tissues, often present on an extremity. The tumor seems to attain a certain size and then grow no more. Some patients complain of tenderness on pressure or spontaneous itching of the lesion. In about 20% of cases trauma, which may be as minor as a scratch or mosquito bite, is recognized as initiating the lesion. Nodular subepidermal fibroma is completely benign and its removal is optional.

The malignant counterpart of a simple fibroma is a *fibrosarcoma.* The clinical characteristics of this lesion are not specific; fibrosarcomas are soft to firm masses which may occur at any surface, the overlying skin being of normal color or showing a red hue. Appropriate therapy consists in surgical removal of the tumor. The prognosis depends on the histopathology present.

At times, variously sized indurated plaques are found on the face, chest, abdomen, inguinal areas, and lower extremities. They are composed of firm to hard, painless nodules, usually red to blue. With the passage of time, a sessile or pedunculated tumor may superimpose itself upon the plaque (fig. 1d). This is *dermatofibrosarcoma protuberans,* a lesion which occurs with equal frequency in men and women. One may suspect myxomatous degeneration if the tumor becomes soft after a period. As with fibrosarcoma, surgical excision is the treatment of choice.

Tumors of Muscle: The tumors of smooth muscle are divided clinically into dartoic myoma and leiomyoma cutis. The former occurs usually as a single lesion originating in the nonstriated musculature in the region of the genitalia or mammae. *Leiomyoma cutis,* on the other hand, consists of groups of usually 20 to 100 variously sized nodules whose color may range from red to yellow to brown. They are asymmetrically distributed over the extremities, the trunk, or the face. Frequently these lesions are painful on touching or slight trauma, thus contrasting with dartoic myoma, which is less sensitive. The onset of these tumors may occur at any time but frequently comes early in life. Surgical excision is advised for relief of the accompanying symptoms.

Granular cell myoblastoma usually is a solitary tumor which originates from embryonal striated muscle cells. It is a globular tumor, slow-growing, whose diameter may range up to several centimeters. Frequently it involves the tongue and mouth, but it may be found anywhere on the skin. This tumor is benign. Surgical excision is the treatment of choice; but because the lesion often is located within the oral cavity, satisfactory accomplishment is difficult.

Tumors of Nerve Tissue: *Neurinoma* (neuroma) is a tumor of nerve tissue which might be confused with leiomyoma. Like the latter, it consists of variously sized grouped nodules over the shoulders, arms, buttocks, and thighs; and they may be painful, with exacerbation of symptoms on changes of temperature. Although one might expect them to be located along the course of nerves,

Fig. 2—Tumors of the skin appendages. (a) Syringoma, a sweat-gland tumor, clinically resembling lesions of lichen planus. (b) Cylindroma presenting as lesions about the hair line referred to as turban tumors. (c) Adenoma sebaceum involving the face. (d) Trichoepithelioma, characterized by minute, pearly papules that involve the central portion of the face.

this is not the rule. Neurinoma is more frequently found in males than in females.

Neurofibromas are easily recognized clinically by the presence of variously sized, soft or firm, sessile or pedunculated tumors occurring anywhere on the body, frequently in association with macular areas of hyperpigmentation (referred to as "cafe au lait spots") in a patient of rather low physical and mental ability. Ordinarily a hereditary pattern of similar involvement among relatives can be found. Tumors localized to specific areas may be cared for by surgical intervention, although surgical excision of all neurofibromas is not possible.

Tumors of Dermal Appendages: The tumors of dermal appendages are perhaps the most interesting among the whole range of skin tumors. *Syringomas* are uniform-sized, red to brown papules grouped over the arms and trunk (fig. 2a). They appear early in life, and most often in girls. The individual lesions are asymptomatic, and their resemblance to the papules of lichen planus is often commented upon. Histologically, it is thought that these tumors arise from the sweat ducts; microscopically dilated cystic sweat ducts are visible throughout the corium. In most instances treatment is not desired, nor is it indicated.

Adenoma sebaceum, as one might suppose, derives its origin from sebaceous glands. Commonly seen are the senile sebaceous adenomas that affect predominantly the forehead, and less frequently the cheeks and chin. They are chamois-colored to brown papules, usually no larger than 3 mm. in diameter, which have a rolled border and are

depressed centrally. Telangiectases may course over the surface of these lesions. They are completely benign and their removal is prompted by cosmetic reasons only.

Similar lesions can be seen on the central portion of the face of children, and nearby on the forehead and chin (fig. 2c). In association with tuberous sclerosis of the brain, mental deficiency, and epilepsy, sebaceous adenoma is a part of the syndrome epiloia. This is inherited through an incomplete dominant mechanism. Invariably the patients die before the age of 20 years.

Some confusion might exist in differentiating *trichoepithelioma* (multiple benign cystic epithelioma) from the aforementioned adenoma sebaceum as seen in childhood. Trichoepithelioma likewise has its onset before puberty, and affects girls more frequently than boys. A hereditary pattern is present in this disease also. The individual lesions are minute, pearly to pale yellow to pink tumors located symmetrically in the central portion of the face(fig. 2d).

Cylindroma has an anomalous place within this group of tumors of skin appendages, for its exact origin has not been determined. The lesion occurs in groups as variously sized, smooth, firm to hard nodules, frequently located about the hair margin, thus aptly suggesting the term "turban tumors" (fig. 2b).The individual tumors are asymptomatic and grow slowly, but may attain a considerable size. Their removal is required only when the size of the tumor interferes with the wearing of a hat, combing of the hair, and so forth. This skin tumor referred to as cylindroma should not be confused with cylindroma of the salivary glands, which is another entity altogether. Cylindroma is at times associated with trichoepithelioma and syringoma.

Metastatic Tumors of the Skin: Metastatic tumors of the skin may involve this organ (1) by direct extension through the skin from an underlying position—for instance, the gallbladder or kidney, (2) by direct lymphatic extension, as in carcinoma en cuirasse, (3) by dissemination through the lymph vessels, or (4) by dissemination through the blood. The carcinomas of specific organs tend to metastasize to the skin, and there is a generally recognized order of source locations in respect to their frequency of doing so: breast, stomach, lung, uterus, and kidney. Approximately one third of cutaneous metastatic tumors are found on the scalp.

Carcinoma en cuirasse is a form of metastatic skin cancer which represents extension of a tumor by direct lymphatic passage. Most frequently—but not always—this is a carcinoma of the breast. A clinical sign is a reddened area of skin which is firm but not hot to palpation. I might say that it looks like an area of cellulitis, but is not. Histologically, the presence of metastatic tumor cells within the lymphatic vessels confirms the clinical impression.

There is nothing clinically specific about cutaneous metastatic lesions except that they tend to be relatively firm nodules which may or may not be grouped. Thus it is well to reaffirm at this point that cutaneous tumors not presenting a characteristic clinical appearance should be biopsied, with the suspicion always in mind that such a tumor may be a metastatic lesion.

Summary

I have tried to classify the various tumors of the skin seen in the practice of clinical dermatology, and to give a few salient clinical characteristics for each kind. Let me emphasize once more that in the absence of a characteristic clinical picture skin tumors should be biopsied so malignant lesions of the skin, either primary or metastatic, may be diagnosed.

Mayo Clinic.

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Hypertension with Unilateral Renal Dysfunction Cured by Nephrectomy

A Case Report

By GEORGE E. MAGNIN, M. D., and NORMAN J. HELLAND, M. D.
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UNILATERAL renal disease as a cause of hypertension is now well established.[1] In some instances the single recognizable manifestation of this disease is impaired function of one kidney.[2,3] One is impressed by the paucity of clinical, anatomical and pathological findings.

It has been estimated that among persons of college age some 5% to 20% have hypertension and that 25% of all deaths of persons over 50 are due directly or indirectly to hypertension.[4] This excludes persons having hypertension due to arteriosclerosis where only the systolic pressure is elevated.

Of all persons with hypertension less than 2% have unilateral renal disease as a cause. Translated by Smith[5] into understandable figures this represents 30,000 hypertensive patients in the United States who are potentially curable by nephrectomy.

Butler in 1937 is generally credited with being the first to recognize clinically the association of unilateral renal disease in hypertension, having cured a child of hypertension by nephrectomy.[6] In the ensuing years many patients were subjected to nephrectomy with the hope that it might cure their hypertension. So disappointing were the results in general that many physicians came to have grave doubt that there was any relationship between unilateral renal disease and hypertension except for a fortuitous one. Homer Smith[1] found in reviewing the literature from 1937 to 1956 that of 575 reported cases of nephrectomy for unilateral renal disease with hypertension, only 26% could be considered successful. It was reported by Braasch[7] in 1940 and more recently reiterated by Thompson[8] that the best results for cure of hypertension by nephrectomy for unilateral renal disease were afforded in those cases where there was unilateral pyelonephritis or pyelonephritic atrophy. The accumulated clinical experiences of the past 20 years, however disappointing they may have been in association with basic research, have been productive in adding to our sound surgical indications for nephrectomy in unilateral renal disease and more particularly in those instances where there is an associated hypertensive vascular disease. We refer primarily to two groups, the first being that of renal artery disease, the recognition of which has been greatly augmented by the use of aortography. The second group is that of unilateral renal disease in which the only finding of significance is that of impaired function, the cause of which may often be obscure and the anatomical and pathological findings may present but little variation from normal.

Clinically this impaired function may be demonstrable by intravenous urography as exemplified in the case to be presented. In other instances the excretory urogram may be normal, but there is reduced excretion of phenolsulfonphthalein by one kidney.[3] Howard[2] has shown that in subjects studied with unilateral renal disease in hypertension there was at least 50% decrease in water excretion and 15% decrease in sodium excretion from the involved kidney. White,[9] working with dogs, found that partial constriction of the renal artery resulted in permanent decrease in excretion of sodium and water by that kidney, providing the other kidney was normal. He also found that this reduction in sodium and water excretion usually occurred before changes in glomerular filtration rate could be detected.

Seemingly, therefore, we may have added to our knowledge of unilateral renal disease by emphasizing the importance of disparity in renal function. This alone might be considered as an indication for nephrectomy when there is associated hypertensive vascular disease.

It is not reasonable to think of subjecting all patients with hypertension to complete urological study including differential renal studies in order to ferret out the small percentage of patients who may have an associated unilateral renal disease. In general intravenous urography should be included in the appraisal of the hypertensive patient. If the hypertension is of recent onset and of the accelerated type for which no cause is apparent, differential renal studies are indicated even in the presence of a normal intravenous urogram. It should be emphasized that disparity in renal size should alert one to the possibility of unilateral renal disease, with the smaller kidney being the initiator of the hypertensive process. Perera and Haelig[10] have pointed out that the patients most likely to receive benefit from nephrectomy are those having a recent onset of hypertension of an accelerated type with a high diastolic pressure.

Once the diagnosis is established, nephrectomy should not be deferred unduly because the pathological process may well produce irreversible changes in the so-called normal kidney, thus the opportunity for cure may be lost.

The criteria for cure postulated by Homer Smith[5] have generally been accepted, namely:

1. There must be a clear demonstration of pre-existing hypertension.
2. There must be a clear demonstration of reduction of the blood pressure to 140/90 or lower after nephrectomy.
3. This reduction of blood pressure must be present at this level for a year or more.

Case Report

This 26 year old white male was admitted to the hospital in August, 1956. On the day preceding admission he had a single episode of painless gross hematuria without other associated general or genito-urinary symptoms. He was seen by his family physician who found evidence of microscopic hematuria, and elevation of the blood pressure to 240/118 mm. of mercury. A complete review of symptoms by systems was negative except for a reported weight loss of 12 pounds, from 142 to 130, during the preceding four months. The patient had a complete physical examination by his family physician ten months preceding this admission at which time the blood pressure was found to be normal and the urinalysis was normal.

A complete physical examination on admission revealed Grade I hypertensive retinopathy, and a Grade II systolic murmur audible over the pulmonic area with accentuation of the aortic second sound. The blood pressure in the right arm was recorded as 230/130 mm. Hg. and in the left arm 210/130 mm. Hg. The blood pressure in the right leg was 280/150 mm. Hg. The remainder of the physical examination was within normal limits.

The urine specific gravity was 1.002, reaction acid, negative tests for sugar and acetone. It contained 100 mg.% of albumin, many red blood cells per high power field, and an occasional white blood cell. Repeated urinalyses showed essentially the same findings. A complete blood count, sedimentation rate, nonprotein nitrogen, fasting blood sugar and electrolytic profile were found to be within normal limits. A chest film was normal. The electrocardiogram demonstrated early left heart strain. Urine smears and cultures were negative for pathogens including acid fast bacilli. Regitine test and histamine test for pheochromocytoma were

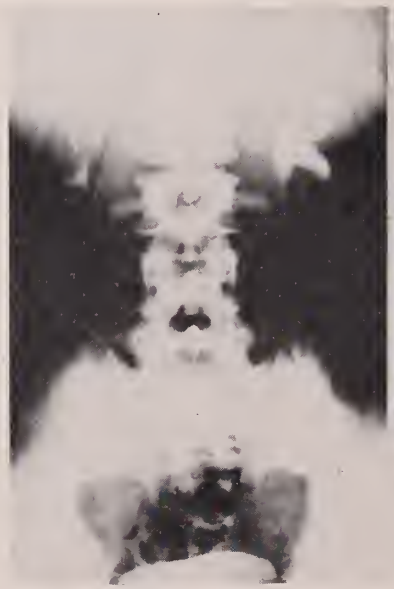

Fig. 1—Intravenous pyelogram. The right kidney is small and has poor function.

Fig. 2—Retrograde pyelogram. The right kidney appears normal.

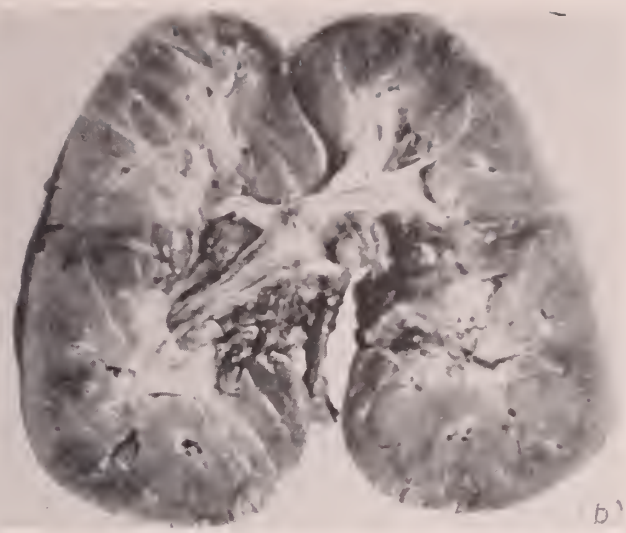

Fig. 3—(a) External appearance of kidney. (b) Cut specimen. Gross appearance of kidney is normal.

negative. Phenolsulfonphthalein renal function study disclosed 23% excretion of the dye in 15 minutes, 19% further excretion at the end of one hour and a total of 59% in two hours. A concentration test showed maximum specific gravity of 1.018. Intravenous urography revealed the right renal shadow to be slightly smaller than the left. (Fig. 1) There was insufficient concentration of the contrast media on the right for diagnosis. The left upper urinary tract appeared normal. The lower urinary tract was normal to cystoscopic examination. Both ureters were catheterized without difficulty. Differential phenolsulfonphthalein excretion study showed 5% excretion from the left kidney in 15 minutes and none from the right. At the end of 45 minutes there was 35% excretion from the left and only 6% from the right. Bilateral retrograde pyeloureterograms again demonstrated the slight disparity in size between the right and left kidneys. The calyces, pelves, and those portions of the ureters visualized appeared normal on both sides. (Fig. 2) Ureteral catheters were left indwelling for a period of 48 hours. A repeat phenolsulfonphthalein excretion test showed essentially the same findings as previously. On the eighth hospital day a right renal exploration was performed. The kidney appeared grossly normal as did the pelvis and upper ureter. The renal pedicle was exposed and the artery found normal to inspection and palpation. This did not rule out the possibility of renal artery disease.

Nephrectomy was carried out. The kidney weighed 109 gm., but was otherwise grossly unremarkable. (Fig. 3a and 3b) Microscopic examination revealed only minimal narrowing of the afferent arterioles and slight thickening of Bowman's capsule. There was no suggestion of chronic pyelonephritis and no evidence of glomerular infiltration either acute or chronic. Pathological diagnosis was hypotrophic kidney with cause undetermined.

During the period of convalescence the blood pressure was never over 140 mm. of mercury systolic or 86 mm. of mercury diastolic. This patient was followed for a period of 18 months. In February of 1958 he was asymptomatic. His weight had returned to its previous normal level. His eyegrounds were normal and his blood pressure was 110/70. Urinalyses performed at this time were normal in every respect. The specific gravity was 1.013.

In conclusion this patient had an accelerated type of hypertension of short duration with high diastolic pressure and early retinopathy. This together with the demonstration of markedly impaired right renal function both by intravenous urography and phenolsulfonphthalein excretion made him a suitable candidate for cure by nephrectomy according to the postulates of Perera and Haelig.[10] Smith's[5] criteria for cure have been

fulfilled in that he had a well demonstrated preoperative hypertension which returned to normotensive levels postoperatively and have remained so for more than one year.

Summary

In summary a case of unilateral renal disease cured by nephrectomy has been presented. The criteria for selecting a patient for surgery with this disorder has been reviewed. The importance of unilateral reduced renal function has been emphasized.

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"Heart Disease of Pulmonary Origin"

Criteria for definite, pure, chronic cor pulmonale are set down and 51 patients who met these qualifications were studied. By far, the greatest incidence is in middle aged white males, though it is seen in all ages, both sexes, and in various racial groups. The asthma-bronchitis-emphysema syndrome is shown to be the principal etiology. The electrocardiogram shows the changes rather late, and in general is of relatively little value in assessing the degree of cardiac change.

Detailed blood volume studies were done in 17 patients with cor pulmonale and six individuals with emphysema. The latter were not consistently abnormal, but those with definite cor pulmonale showed a variable increase of total blood volume, and a consistent increase of red blood cell mass. In management of these patients, the importance of prophylaxis, early recognition, and energetic treatment in the early phases, even before cardiac changes are manifest, is strongly emphasized.

"First and foremost in management are measures aimed at alleviation of bronchopulmonary condition and any contributing focus as sinusitis or tonsillitis. We would again emphasize the value of antibacterial agents for the prompt control of bronchial infection in a primary or recurrent flare-up. Bronchodilators, as antispasmodics, amino-phyllin, wetting agents and mucous digestants have been used frequently in recent years in our hospital.

"The most common plan has been a combination of aerosols as ISUPREL aerolone and ALEVAIRE, in equal parts, either by a No. 40 De Vilbiss nebulizer, or with intermittent positive pressure oxygen apparatus . . . Amino-phyllin (0.25–0.5 gm.) intravenously is often life saving. Abdominal pads and binders or pneumoperitoneum . . . may sometimes help. Management of cardiac complications has largely been directed toward an attempt to correct myocardial failure and includes venesection, administration of digitalis and diuretics and measures to reduce oxygen requirements of the tissues." —*Hermann, G. R. and Shields, A. H.: Dis. Chest 33:52 (Jan.) 1958.*

Pamphlet Available on Protection Against Epidemics

"Suggested Recommendations for Prevention and Minimizing the Effects of *Hospital Infections*, with Special Emphasis on *Staphylococcal Infections*," has been prepared by personnel of the State Board of Health as a guide to hospitals and physicians for their protection against unfortunate epidemics. Consultation and help in reviewing individual hospital situations and adapting procedures to local hospital needs is provided through the Wisconsin State Board of Health. Additional copies are available upon request. Address: WSBH, 1 W. Wilson, Madison, Wisconsin.

Hypometabolism or Hypothyroidism

By HUGH PAYNE GREELEY, M. D.
Madison, Wisconsin

THE DEVELOPMENT of a simple machine for measuring oxygen consumption and calculating the basal metabolism came at a time when all the emphasis was on hyperthyroidism. In the last 35 years, the number of people with elevated basal metabolism has declined, and now the emphasis is on patients with low oxygen consumption.

It may, therefore, be worth our while to consider some of the problems that have arisen since those early days. First, as to the accuracy of the test: the technical difficulties have been largely overcome, though errors do occur, and we must check mouthpieces, leaky valves, soda lime, tubing and so forth, as well as room temperature, the patient's comfort, and his surroundings.

Of more importance are the well known internal factors[1] that have to do with the subject himself: his temperature, pulse rate, clothing, previous night's rest, the outside temperature he encountered on his way to the laboratory, and his body build. What is his state of nutrition? Is he obese or underweight? Is he post-infectious? Has there been loss of weight, anemia, or an allergic state? What are his diet habits, his daily activities, his adjustment to work and home life, his anxieties, his susceptibility to exhaustion and chronic fatigue? Is the low metabolic rate a familial trait? All of these factors may make a difference of many per cent, and some may cause readings from 12% to 32% below normal. The former "normal" range from minus 10 to plus 10 is no longer valid; the consensus being that present figures are minus 20 to plus 20.[2]

Since the oxygen consumption decreases with age, lower figures are more frequently found, and in an adult population vary widely. Not only are basal rates low, but the expenditure of energy when normal people perform identical tasks may vary as much as 40%.[3] Energy requirements exhibit wide variations, much more than was formerly thought.

In hospital determinations we are not presumably dealing with wholly normal patients, though a great many tests are done as part of a thorough examination. After the recent publication of an article in a popular monthly magazine, the number of tests done in the laboratory of the Madison General Hospital was doubled. About 500 tests are made there yearly. The following are the results of 370 recent tests: 165 were plus to minus 10; 112 between minus 10 and minus 20; 59 between minus 20 and minus 30; and 4 below minus 30. Only 17 tests were over plus 10; 8 over plus 20; 4 over plus 30; and 1 over plus 40. In other words, there were 13 over what is considered a normal figure against 63 below. (During the summer there were only 2 cases below minus 20. In April and May there were 10 less than minus 20. In winter there were 27 less than minus 20, or fourteen times as many as in summer and twice as many as in the spring.)

What then is the explanation of these figures? Let us assume that the absence of high figures is due to a *real* falling off in the incidence of hyperthyroidism. Do these low figures represent a recent change in the persons tested, or have their metabolism rates always been in this range? We do not know. Under ideal circumstances, determinations should include observations of an individual over a period of years.

The generally accepted basal metabolic rate in myxedema is between minus 33 and minus 40. In this series, only 2 cases could qualify on this basis. Osler saw 10 such cases during a 16-year period; Plummer saw 51 cases in 4 years.[4] Two cases out of 370 would then be about the same proportion, but such a low metabolic rate might indicate pituitary rather than thyroid deficiency. Therefore, one must look for other endocrine disturbances.

What about the 59 cases with rates between minus 20 and minus 30? That present emphasis is on lowered metabolism rather than on elevated is true, and these figures may represent diagnostic selection in that the low figures were clinically expected. In addition we will grant that as the years pass

laboratory techniques improve, and we have more truly basal conditions and consequently lower basal metabolism readings. But the problem remains of the correct interpretation of the test. For instance, we must look with suspicion on the tests in which the basal metabolic rate is minus 20 to minus 30 with a pulse of 80 to 90, as we always have on a reading of plus 50 and a pulse of 70. If a correction for the patient's early morning fasting temperature is *not* made, the test is probably off 7% to 10%, many patients at this hour having a temperature under 97.6 F. A difference of 1 degree above or below normal raises or lowers the metabolic rate that much.[5] Very low rates are found following infections, in the obese, in exhausted individuals, and in those on low protein diets. In fact, after a weight loss of 10% or more, the rate is 20% below normal.[6] There are so many clinical conditions associated with lowered oxygen consumption that interpretation requires careful judgment, and one cannot conclude that hypothyroidism is present. The tranquilizers and muscle relaxants, though their effect on the metabolic rate is not recorded, must lower the basal metabolism appreciably. Muscle tension and shivering greatly increase the metabolic rate.

The wide difference in the number of tests under minus 20 in summer and in winter, we may assume, is due to the external conditions of a steam heated room between 73 F. and 85 F. and warm clothing, as against a summer morning temperature under 73 F. with less clothing and without artificial heat. The lowest rates are found—winter or summer—in a room temperature between 73 F. and 85 F., and these rates should then be considered within a normal range. Since in these hypometabolic states the present investigators find that the iodine uptake and protein bound iodine or butanol extractable iodine are normal, we are not justified in making a diagnosis of hypothyroidism on the sole basis of a low basal metabolic rate. In addition to the basal metabolic rate, cholesterol values in the blood, protein bound iodine estimations and/or radioactive iodine uptake should be done for added evidence. If these are normal, there is *no* hypothyroidism.

But, one may say that the thyroid may be normal, but there is a failure to utilize thyroxin at the cellular level, and that one of the iodothyronines, the real cellular metabolic stimulants, is not functioning to de-iodinate thyroxin.[7-10]

There is evidence to support this theory, but as yet it is insufficient, and many of our best internists are still vainly searching for such a condition in their patients. There is evidence against this theory, however attractive it may seem. We all agree that low basal metabolic rates are found much more commonly than formerly. What is the reason? We now know that the thyroid is only one organ that exercises control over energy metabolism, and that the pituitary, adrenals, and gonads play very important roles, and the hypothalamus is the primary regulator of all. The question of the failure of thyroxin at the cellular level because it is not transformed to triiodothyronine is not fully proved. It may pass—as the extreme low fat and low cholesterol diets to prevent arteriosclerosis are passing—or it may be replaced or greatly altered with the accumulation of more knowledge.

There are many known causes of low basal metabolism which operate in these patients with rates under minus 20. Recent discussions list the signs and symptoms in hypometabolic states which are given as indications of need for specific thyroid medication.[11] The list includes all those which have been recognized for years in myxedema and which do not need enumeration because they are present in 70% to 90% of all cases. Other symptoms which are present in from 10% to 50% of cases are more characteristic of patients with neurasthenia, the menopause, obesity, chronic nervous exhaustion, anemia, anorexia nervosa, chronic anxiety states, amenorrhea, impotence, nervousness, lack of energy, insomnia, palpitation, loss of memory or interest, muscular aches and pains. Such subjective symptoms are difficult to interpret, and their reversal is never accompanied by objective signs of improvement.

The clinical reports of enthusiasts for the use of triiodothyronine leave much to be desired because of the absence of controls, fewness of cases, incomplete diagnoses, and inadequate follow-up results. When improvement in symptoms results in patients *without* change in weight or in serum cholesterol or in the disappearance of physical signs, we have inadequate proof of the need for thyroid medication. A sense of well being is insufficient.

These new and highly potent preparations are four or five times as active as desiccated thyroid or thyroxin,[12] and produce a rapid stimulation and tonic effect. It has long been known that when using desiccated thyroid in any person with a normal gland, the gland ceases to manufacture thyroxin by an amount equivalent to what is being taken. At the end of two weeks or so the patient is then exactly where he was when medication was started, and symptoms have returned. The doctor is inclined to feel that the dosage is insufficient and so increases it. This continues until the patient gets discouraged and changes doctors, or until psychotherapy and general measures of hygiene and other supportive treatment which have been instituted have taken over and the patient remains much improved. This frequently takes place without any effect attributable to the medication, as the patient remains in equilibrium *until* he *stops* his medication. *Then* for the first time he is *really hypothyroid*. It takes only 100 to 200 mg. of desiccated thyroid to suppress thyroid function, and the patient who stops taking his medicine is now without any. It may take his own thyroid gland perhaps some weeks to start functioning adequately once again. There are instances of patients whose glands never start again if the thyroid medication has been given over a long period.

In myxedema with all the classical signs and symptoms, 30 mg. of desiccated thyroid is often enough to reestablish function. However, the average dose is 100 mg. This being the case, one would never be justified in giving larger amounts to any patient when the metabolic rate is between minus 20 and minus 30. It is stated that some patients do not respond to desiccated thyroid, but that they do respond to triiodothyronine, which is five times more active. In equivocal cases, a clinical trial of this drug does not prove its need any more than whipping a tired horse proves he was not tired. Because of this more potent action, it is a much more dangerous drug; and the occurrence of complications, such as angina, may rapidly develop from its use.

The use of thyroxin, desiccated thyroid, and preparations of diiodothyronine are unjustified in patients with low basal metabolism, unless there is added evidence of hypothyroidism. No one would think of trying to raise a pulse of 50 to 70 beats per minute, because that figure is more normal. Basal metabolic rates in the lower brackets are explainable in many ways. Such patients may react to the stress of living by cutting down their energy requirement. The hypothalamus—the real director of the orchestra—may call for pianissimo. The low oxygen consumption may be a measure to save energy. The treatment for the patient would then be better adjustment and the education of the emotions.

In conclusion again let me stress the point that the important factors are multiple. A low basal metabolism, a protein bound iodine below 5 mcg./100 cc., a radioactive iodine uptake under 15% of the ingested dose, and an elevated cholesterol are what indicate hypothyroidism. One cannot correctly interpret a patient's condition from basal metabolism readings.

Hypometabolism should not be treated with substitution therapy. This would be a case of the tail wagging the dog.

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POISON CONTROL

. . . A Vital Factor in Wisconsin Health and Safety

POISON CONTROL IS FIRST OF ALL, PREVENTION

Most parents know that childhood is an inquisitive age. Not all of them use this knowledge and so fail to keep all household poisons under lock and key. Constant reminders are needed about such things as cosmetics, drugs, cleansers, fertilizers, and insect sprays. Aspirin and kerosene require special care.

POISON CONTROL IS ALSO PROMPT ACTION

Parents should know that calling a physician is the first thing to do when a child has swallowed poison or is suspected of swallowing a poison-containing substance. Waiting for symptoms can be fatal.

EVERY HOSPITAL EMERGENCY ROOM SHOULD BE PREPARED

Every hospital emergency room is called upon from time to time to give treatment to a poison victim, usually a child under five years of age. When the poison is known, the proper antidote or treatment can be administered promptly. If the ingredients of the substance swallowed are unknown, the physician or emergency room personnel can call one of the poison information centers described below for information on the product, the antidote, and the treatment procedures. In either case, equipment and supplies must be readily available to remove the poison if possible, to give antidote, and to administer other supportive therapy. (See page 128 for references)

Physicians Should Know These Life-Saving Numbers

The statewide poison information center was established by the University Hospitals' Department of Pediatrics in April, 1958. The University Departments of Botany and Agronomy and the School of Pharmacy cooperate. Directed by Dr. W. T. Bruns, the center gives information on poisons 24 hours a day, seven days a week. Physicians or hospital emergency room personnel may learn by phone the ingredients and antidotes of many poison-containing preparations.

MADISON
ALpine 6–6811
University Hospitals Poison Information Center, Madison

A poison control center for Milwaukee and surrounding area was begun in 1957 by the Academy of Pediatrics under the leadership of Dr. Frank Mellencamp. The center for information is set up in Children's Hospital. Emergency care is given there as well as at Johnston Emergency, County Hospital, and Columbia Hospital.

MILWAUKEE
DIvision 2–6360
Poison Control Center Children's Hospital, Milwaukee

The poison information center for the Kenosha area is operated as a part of the emergency room in the Kenosha Hospital and is directed by Dr. W. D. Davis. It was established by the Kenosha County Medical Society "to make Kenosha a safer place to live." The Kenosha Pharmacy Association co-operated in establishing the center and donated reference material.

KENOSHA
OLympic 4–5311
Poison Information Center Kenosha Hospital, Kenosha

OTHER STATE AREAS

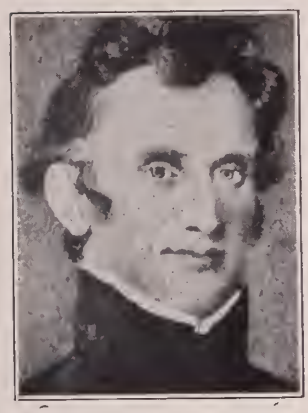
While the three centers above may be contacted, every hospital emergency room should have poison treatment equipment and supplies available at all times and should have someone trained in their use.

RECENT ARTICLES PUBLISHED IN THE WISCONSIN MEDICAL JOURNAL

The June, 1958, issue included the article, "Report on Poison Control Centers, Milwaukee County, 1956," by Dr. Franklin J. Mellencamp, and an article, "Accidental Poisoning," by Dr. Carl N. Neupert was printed in the October, 1958, issue.

The First William Beaumont Lecture*

By BURRILL B. CROHN, M. D.
New York, New York



William Beaumont, M. D.

Pioneer Gastric Physiologist of the United States

IT IS BEFITTING that the Medical Society of the great State of Wisconsin should have established a *Beaumont Foundation Lectureship* in honor of William Beaumont, pioneer gastric physiologist of the United States. While in Wisconsin, he conducted a series of scientific observations upon the human stomach that ennoble the annals of medical history, a pioneer and unparalleled achievement of simple scientific observation and research.

The bleak military post at which Beaumont conducted his experiments, Fort Mackinac, lies north at the junction of Lake Michigan and Lake Huron, a site which was then within the Territory of Michigan. It was a cold, dreary, and isolated defense post housing a small detachment of the army. The post was visited annually by a motley crowd of French Canadian trappers who, bringing in their annual fur bounty for sale to the American Fur Company, rowdily feasted and drank away in a debauch the hard-earned fruits of their rigorous hunting of the winter months. There in 1822 Beaumont met with his illustrious subject Alexis St. Martin.

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William Beaumont descended from old New England stock of French origin who had immigrated to the States from England over a hundred years before. Born in Lebanon, Connecticut, in 1785 of severe, stolid, God-fearing Calvinistic ancestors, he was a true scion of that puritanical breed, a great moralist, a young man of strict probity, capable, serious thinking, a man whose standards of ethical conduct would grace a character from the Old Testament.

Apprenticed to Dr. Benjamin Chandler of St. Albans, Vermont, he showed an early predilection for the study of medicine and developed the capacity for keen observation and scientific interest. In three years under the guidance of his eminent preceptor he was, in 1812 the year of the War with Great Britain, licensed to practice medicine. He immediately joined the U.S. Army and was commissioned as an assistant surgeon.

Note that his medical training was of the most practical nature, that formal instruction was lacking and that education in the basic sciences was completely absent. Physiology, laboratory research, and the scientific quest for investigation were unknown in the bleak and isolated towns of northern New England or in the then sparsely settled forests of the Middle West. His medical training under Doctor Chandler was probably that of the English or Irish school of clinicians who were noted for their keen and original observations and practices in pure clinical medicine. The later era of the dominance of French medicine and the still later

era of the brilliant German and Austrian schools with emphasis on pathology and experimental observation were still far in the future. In fact, Beaumont was not far separated from the era when Perkin's tractors and magnetic medicine represented the vogue in practice, and fancy and farce were substituted for pure empirical bedside clinical observation.

In June 1822, Beaumont was called upon to treat the critical wound of a half-breed trapper, Alexis St. Martin, who had been accidentally shot. Slugs of buckshot, entering from behind, had torn a large aperture through his left pleural cavity, lung, and stomach. Beaumont spent three years nursing and caring for the wound; he was unable to close the aperture in the anterior abdominal wall into which the walls of the stomach had become permanently adherent.

For three years he cared for the trapper with conscientious solicitude and personal attention since no provision had been made at the Fort for the upkeep of such an indigent and also to prevent the deportation of his prize back to Canada. In the words of Beaumont's diary "he remained with me for two years during which time I nursed him, fed him, clothed him, lodged him, furnished him every comfort, dressed his wound daily with the hope of saving his life or at least making him comfortable." At this time Beaumont realized what a rare and unusual opportunity had been afforded him for the study of the physiology and chemistry of gastric digestion. Quite obviously Beaumont was unaware that in the foreign literature cases of this or similar nature had occurred in the hands of past surgeons, but none of these practical men had realized or utilized the marvelous opportunity afforded to them by this accident of nature.

By contract for $150.00 a year for two years, Beaumont bound St. Martin to him as a subject for observation and benign experimentation, paying the sum out of his munificent salary of $40.00 a month at the cost of deprivation to his family of luxuries and possibly comfort. He began these physiological observations at Mackinac, and then continued at Plattsburg on Lake Champlain, New York, then at Green Bay and Prairie du Chien in Wisconsin. St. Martin had decamped, or taken French leave, in 1825; however, at great expense and effort and with the help of American and Canadian officials, he had been returned to Beaumont at Prairie du Chien to allow for an extension of the earlier physiological experiments. This was during the period from 1829 to 1833.

The precious monograph, "*Experiments and Observations on the Gastric Juice and the Physiology of Digestion*", by William Beaumont, was published at Plattsburg, New York, in 1833, and is a recital of the simple observations which this untutored and uninitiated backwoods physiologist made upon his unusual subject. With nothing more than a thermometer, a sand bath, and a few open vials he was able to disprove the previous theories that gastric digestion was "macerative and putrefactive," induced by acetic acid, and that muriatic or hydrochloric acid was probably present in gastric secretions. He suspected the existence of pepsin but was unable to isolate or confirm this fact. Actually Prout, in 1832, had discovered hydrochloric acid as the main acid ingredient of gastric secretory activity; pepsin was isolated a short time later, in 1835, by Schwamm.

Beaumont's Observations

Beaumont's observations covered the entire field of gastric digestion as it was then understood. He counted the time of digestion of various articles of food, simple foods and compound ingredients, the effects of alcohol on digestion, and by the movements of his long thermometer discerned peristaltic activity. He studied appetite, hunger, and thirst in his primitive manner. In later life he studied assiduously in Washington the writings of Spallanzani, Tiedemann, Gmelin, Prout, and Abernathy; and he made notes that his observations on St. Martin corroborated their previous observations which were more nearly clinical surmises than actual human observations.

Experiment 34, March 14, is of unusual interest for us. In this incident he makes first note of the effects of anger and impatience in retarding the progress of digestion. While older clinicians for centuries—probably even Hippocrates—had noted the effects of emotion upon digestion, Beaumont's keen intuition is the first human concrete physiological and psychological observation to confirm what previously was only a clinical surmise. In Experiment 34 Beaumont unwittingly laid the foundation for what years later would be known as "psychosomatic medicine."

Many decades later, in 1897, Pavlov published the Russian edition of his "*Work of the Digestive Glands,*" a series of outstanding observations experimentally carried out on his faithful dogs. In these studies he laid the cornerstone of our modern concept of the physiology of the salivary, stomach, pancreatic, and intestinal glands, the bile and succus entericus, and the effects of psychic stimuli on secretion as afforded by his unique Pavlov pouch in dogs. But Pavlov was an experimental physiologist, restricted to animal experimentation. Without clinical knowledge he failed to apply his keen research motivation to the problems of human functional or neurotic disturbances. Later in his studies on conditioned reflexes he began to approach unwittingly the entire but unknown field of human functional illness.

By means of an artificial gastric fistula in dogs, Boldyreff studied the movements of the empty stomach. Dr. A. J. Carlson, that dynamic Scandinavian, also had like Beaumont, the unique opportunity to study gastric physiology directly in the human stomach. "Mr. V." had had a complete closure of the esophagus due to caustic and a permanent gastric fistula of 20 years standing. The gastric fistula was large enough to permit direct inspection of the interior of the stomach and the introduction of balloons, rubber tubes, and small electric lights for direct observation. Carlson studied the control of hunger (and appetite) in health and disease. He studied in "Mr. V." the relation of hunger to appetite, the nervous control of the hunger mechanism, and the secretions of appetite juice and its chemical composition. Carlson working with a second "Alex. St. Martin" made the most valuable and novel experimental observations, again on a human subject; but, not being a clinician, he failed to derive from his observations—keen as they were—the implications and applications of his findings to humans in the throes of anxiety or emotional stress.

In 1915, Walter B. Cannon, Professor of Physiology at Harvard University, published the results of his observations on the effect of human stress in, "Bodily Changes in Hunger, Fear, and Rage," emphasizing the importance of the adrenal in the mechanisms of human defense under the effects of emotion and fatigue. This brought us a step closer to the application to clinical medicine of the knowledge gained by Beaumont and Carlson. The concept of psychosomatic disease, of actual pathological changes as caused by psychic trauma, had not yet been formulated but was in the offing. Still we were lacking clinicians; we were replete with physiologists, but no one since Beaumont had been a practicing physician.

The actual approach to the concept of psychosomatic medicine came, however, not from the physiologists and the clinicians but from the psychiatrists following upon the initial teachings of the great master and innovator Sigmund Freud.

Dunbar (1938) in "*Emotions and Bodily Changes*", Alexander (1936) and Deutsch (1939) began to extend the teachings of Freud to somatic medicine. Freud's dynamic conception of emotion referred only to the transformations of psychic energy into various patterns of emotional or mental behavior.

These later psychiatrists felt that Freud had neglected the fact that many of his cases and observations revealed the transformation of psychic energy and trauma into true physical symptoms related to disease entities, which might be called by some genuine somatic illnesses. This beginning concept of psychosomatic disease was carried on by thoughtful workers such as Kubie, Margolin, Drinker, Reusch, and by Wolff who in his book "*Life Stress and Bodily Disease*" epitomizes the relationship of emotion to actual somatic changes.

Later Recordings Stem from Beaumont

Have we strayed far from William Beaumont? Not at all, because we return now to a series of most interesting and valuable observations, experimental and clinical, on human subjects. These recordings are the direct heir to those of Beaumont, following the methods used by our pioneer surgeon-physiologist, but now with the greater knowledge of psychiatry and its application to true psychosomatic medicine.

In their studies on human gastric function, Wolf and Wolff studied the gastric fistula of their subject "Tom," who at the age of nine developed an esophageal stricture from drinking hot clam chowder. This required a permanent gastrostomy for feeding purposes. Not unlike St. Martin, "Tom" was a sensitive, proud, and independent individual. At different times he was anxious, fearful, difficult, and obstinately decisive. In their prolonged studies on "Tom", they observed

that frustration and repressed conflict were associated with hyperemia of the gastric mucosa with increased motility and secretions. At times the engorgement of the mucosa as a result of psychic frustration was so intense as to cause increased fragility, a tendency to bleed on the slightest trauma, and even to the formation of superficial tiny bleeding ulcerations. On occasion the contrary took place and fear, anxiety, and hostility would cause excessive blanching of the mucosa of the exposed stomach. The same effect could be produced by moodiness and depression. When in a fighting mood, "Tom" would pour out three times the volume of hydrochloric acid and the mucous membrane was turgid and engorged; when diverted by conversation the engorgement subsided; when threatened with financial insecurity the sensation of heartburn developed; emotional conflict would produce real pain.

We are approaching nearer and nearer to a true concept of psychosomatic medicine. We are still not too far away from the original observations of Beaumont.

Margolin and his associates studied the *"Variations of Gastric Function During Conscious and Unconscious Conflict States."* Their patient was a female with an extremely large gastric fistula created for the relief of complete esophageal closure. They found gastric secretion inhibited by anger, resentment, or fright but found constant changes in the exposed gastric mucosa resulting from feelings of intense guilt, worthlessness, and mental conflict.

The reactions of the human gastric mucosa to emotional conflict can apparently be duplicated in a manner and degree with those of the colonic mucosa. Grace, Wolf, and Wolff utilized four fistulous human subjects for a series of interesting observations on the effects of emotion upon the colonic mucosa.

In two of their subjects the fistula exposed the right colon; in another, the mid or transverse colon; and in the fourth, the left colon. The contractile state of the exposed colon, motor activity, color, fragility, and amount and quality of secretion and its pH and lysozyme concentrate were estimated under conditions of normalcy, and during variations of emotional temperament. In their four subjects with permanent colonic stomas they were able to study the effects of spiritual dejection, disappointment, and frustration which were evidenced by decreased motility, absence of spontaneous contractions, and constipation. During periods of calm and security the colonic mucosa was moist and relaxed; during periods marked by anger and resentment the colon was hyperemic, engorged, and hypermotile; the mucus secretion was thick, tenacious, and opalescent. It was demonstrated that the colon did participate in reactions to stressful life situations.

Almy and his associates made a similar set of observations using the sigmoidoscope and intra-rectal balloons and kymographic recordings as a substitute for direct study of the exposed mucosa in colostomy cases. Through the sigmoidoscope the same effects of physical pain, emotional storm, and mental distress could be ascertained, also abnormally occlusive spasm and moderate engorgement of the mucosa.

Psychosomatic Medicine

The concept "psychosomatic disease" is one in which a pathological state of disease is induced by, or caused by, or aggravated by psychic states of emotional stress and anxiety. The motivating element is either a single traumatic incident or repeated unrelieved states of mental torment or frustration to life situations and hazards. The acceptance of psychosomatic disease has been rather retarded in the profession; and yet, with more time and experience and with an open mind a large proportion of our internists and scientists have accepted, often reluctantly and belatedly, the concept that anxiety can produce or certainly can aggravate preexisting states of disease.

Probably the two most typical and characteristic of the psychosomatic diseases are peptic ulcer and ulcerative colitis, and here all of the observations of the scientists from Beaumont down through the hierarchy of his successors bear witness to the truth that emotional stress does play a direct role in the production of gastric and colonic disturbances of function, and by inference possibly also of disease. All of the subjects of experimentation and observation were persons of temperament, headstrong, prone to emotional upset with heady problems of life conflicts. This applies to Alexis St. Martin, to "Mr. V.", to the subject of Margolin's studies, to the four afflicted persons with colonic stomas as noted by Grace, Wolf and Wolff, and to many of the persons experimentally observed by Almy. And all of this

school of direct study and observation was carried out, like that of Beaumont, on the exposed human mucosa.

Peptic ulcer, in man, is the most typical of the psychosomatic diseases. An emotional trauma is transmitted from the cerebral lobes to the hypothalmic control center; thence via the vagus nerve (or the endocrine corticosteroid system) to the gastric mucosa. The mediated result consists in gastric hypersecretion, vascular engorgement, surface mucosal ulcerations akin to, though not identical with, the typical human peptic ulceration.

It is generally accepted that except for the recognized seasonal variations in ulcer, the most frequent acknowledged cause of ulcer recurrence is stressful life situations and states of recurrent anxiety. Every practitioner has seen hemorrhage occur as a complication of ulcer, resulting from crises of temperament; and a good internist must be a homespun psychotherapist to the extent of realizing that unless stressful life situations are solved for the patient, permanent relief, or "cure", or prolonged clinical remissions of ulcer are remote possibilities.

The same applies to ulcerative colitis, a virulent disease of unknown origin, infectious or viral perhaps, but one in which psychic trauma plays a great role. Many of us with broad experience have seen cases in which a single excessively violent psychic insult has initiated, or caused, or has been concomitant in time with the initiation of severe febrile, toxic, fulminating ulcerative colitis. Certainly every physician who undertakes to treat this disease recognizes the role of psychic trauma in the initiation of recurrences and has seen a quiescent state of complete remission changed into active disease as a result of sudden anxiety, frustration or a critical life situation. Nor can a subject of ulcerative colitis ever be expected to be "cured" or sent into a stage of long remission unless the subject of the disease and his physician are in spiritual rapport and sympathetic understanding, the one to the other. Nor can such a subject of psychosomatic disease ever be permanently assisted back to health unless the causes of recurring emotional discord are removed and eliminated.

Much of this knowledge originated in the simple observations initiated by William Beaumont and carried on by other experiments on humans, by physiologists, by clinicians, and by psychiatrists. To Beaumont let us give tribute, because in Experiment 34 he laid down the foundation stone on which was later created the superstructure of the concept of psychosomatic medicine.

Beaumont recognized the true importance of his observations; he fretted that in his ignorance of even a primitive knowledge of chemistry the work was incomplete. He wished to have contact with better trained scientific minds who could more adequately interpret his results, who could more accurately explain the chemical phenomena of digestion, the role played by acid and the supposititous pepsin. The latter years of William Beaumont's life were years of disappointment and frustration. He had hoped that the War Department would provide the financial means for a trip to European centers with the cherished hope of submitting Alexis St. Martin to the more critical experiments of Berzelius of Sweden or of Claude Bernard in Paris since the help of such American physiological chemists as Silliman or Dungilson had been of no avail. Permission and means to travel were never granted by the War Department; he was ordered transferred to Florida and later to Jefferson Barracks, Missouri. He resigned his commission in protest and developed a large and lucrative private practice. Following a severe fall he died and was buried in St. Louis in 1852, 67 years of age, disappointed and aggrieved.

Beaumont's Personality

William Beaumont was a man of great modesty, with a limited scientific education, but one endowed with the zeal and instinctive purposefulness of a great observer. In prosecuting his experiments and inquiries he believed himself to be guided by the light of unadorned truth.

The personality of the man is best perceived in his own words as given in the preface to his book: "I submit a body of facts which cannot be invalidated. My opinions may by doubted, denied, or approved according as they conflict or agree with the opinions of each individual who may need them, but their worth will be best determined by the foundation on which they rest—the incontrovertible facts."

He was gifted with strong powers, a natural sagacity; his temperament was ardent,

but his perceptions were guided by a balanced judgment and a love for the truth.

The brilliant observations of Beaumont were not long in receiving acclaim and recognition throughout the scientific world. By 1826 the German literature in Hamburg recorded the preliminary announcement of Beaumont's work; this was followed by notices in the Edinburgh Journal of Medicine and, in 1828, in the French Archives Generales de Medicine. In 1834, one of the Italian journals (Anali Universali de Medicina) devoted 20 pages to reprinting the experiments of Beaumont. The famous *Handbuch of Johannes Müller* in which he lays down the groundwork of experimental observations in medicine pays great tribute to William Beaumont (1834), as do also the publications of Carl Christian Schmidt.

The well-known Scotsman Andrew Combe, who strangely enough combined phrenology with very acute and capable clinical medicine, gave great credit and space to Beaumont's observations in his *"Physiology of Digestion"*, published in 1838. A friend of Combe in the United States had sent him a copy of the original work, and Combe was most anxious to publish an English edition that would publicize and give recognition to this classical American treatise. Blondlot, professor of chemistry in Nancy, France, at first deprecated the observations of Beaumont, but on repeating these experiments on dogs he ended by enthusiastically crediting the full truth and exactitude of Beaumont's original researches (1843). William Brinton, the first English gastroenterologist, based his understanding of human digestion on Beaumont's work. Karl Ludwig, the great German physiologist, and Claude Bernard, the most famous French physiologist, in his *"Lessons of Experimental Physiology Applied to Medicine"*, gave Beaumont much space and credit. Kussmaul of the soft rubber gastric tube, and Ewald of the test-meal base many of their observations on the findings of Beaumont. Bayliss, Knud Faber, and Konjetzny pay tribute in their work to that of Beaumont.

You, citizens and physicians of Wisconsin, do well to have established a permanent monument in the form of this Memorial Lectureship, dedicated to the perpetuation of the memory of the first American physiologist to study human gastric function. From the early work of this backwoods physiologist has descended with each generation a succession of observations and experiments of increasing accuracy and importance until the sum of these fractional observations, massed together, form the foundation stones upon which much of our present day knowledge of medicine is so firmly anchored.

18 East 84th Street.

Aids to Promote Health Careers in Local Communities

A film and a pamphlet are proving valuable additions to the growing list of available resources to promote Health Careers in local communities. Do your local health career committees know about these?

"Helping Hands for Julie." Produced by the American Medical Association, the American Hospital Association, and E. R. Squibb & Sons. A 30-minute black and white sound film to interest students in the rewards of careers in medicine and health. It is available on loan, without cost, for showing to audiences in high schools, church groups, community organizations, *and* on television. Order from: Association Films, Inc., 347 Madison Avenue, New York 17, New York.

"Decision for Research." Produced by the American Heart Association as part of their new program designed to help reduce the shortage of manpower in the biological sciences, especially in research. E. R. Squibb & Sons also assisted in the publication of this pamphlet. This pamphlet has been prepared to answer and follow-up on the inquiries resulting from the AHA television series of the same title. The pamphlet is available through local Heart Associations to interested students and schools.

The Role of Exercise in the Treatment of Postural Low Back Pain

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ONE OF THE MOST frequent problems encountered by the physician is that of low back pain. In approximately 80% to 90% of patients having backache the causative factor is some postural abnormality. Goldthwait[1] expressed the opinion that 90% of backache is due chiefly to the wrong use of the back or faulty body mechanics.

Faulty posture may be present as the primary causative factor or it may be the result of some underlying mechanical organic defect. The discussion in this paper will be confined to the primary type; however, it should be noted that the exercise routines presented may be applied also to similar postural deformities which are secondary to other causes.

Pain is usually the most frequent and prominent complaint. There is an increase in all the normal curvatures of the spine, with sacroiliac and lumbar tenderness. The condition is due to an imbalance between the functional capacity of the back and the demands made upon it. It is well known that re-establishment of the normal balance affords relief. This can be accomplished by the institution of therapeutic exercises.

Corrective or therapeutic exercise can be defined as "the scientific application of bodily movement designed specifically to maintain or restore normal function to diseased or injured tissues."[2] In its application to faulty posture therapeutic exercise results in improvement in body balance and coordination of movement of all the segments. The ultimate goal, however, should be the correction of total body balance and function.

The purpose of this paper is twofold. First, an attempt will be made to show the relationship between defective posture and low back pain, and secondly, to present the principles underlying the treatment of this condition with corrective exercises.

The Development of Posture

The spine of the human being develops from the straight rod of the notochord of the embryo to the functionally curved back of the child. The curves normally seen in the adult are not very marked in the infant at birth, but develop as the child begins to function. At first a single dorsolumbar kyphotic curve develops, and only later when the child learns to stand does this develop into the dorsal kyphotic and lumbar lordotic curves. The act of crawling helps to develop the cervical lordosis early. On assuming the erect position, the fetal posture of lumbar spine flexion, hip and knee flexion changes to extension and in the back often proceeds even to extreme lordosis and hyperextension.[3]

The center of gravity of the human being usually is considered to be at the level of the promontory of the sacrum. The line of gravity, which is important in relation to posture, usually runs about 4 cm. in front of the plane of the ankle joints, continues upward just behind the plane of the patellas, then just behind the plane of the greater trochanters of the femurs, in front of the sacrum, intersecting the lumbosacral joint, behind the lumbar portion of the spinal column through the joint between the highest lumbar and lowest thoracic vertebrae, in front of the thoracic portion of the spinal column through the joint between the highest thoracic and lowest cervical vertebrae, then behind the cervical vertebrae to the skull.[2]

The center of gravity and lines of force vary with position and motion. The relation of the center of gravity to supporting areas is the principal factor in equilibrium. When equilibrium is lost there is an immediate attempt to regain it by bringing into action

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various groups of muscles. Therefore, anything which constantly displaces the center of gravity and line of gravity will result in increased stresses and strains on various groups of muscles and joints since a constant state of disequilibrium will be present. If this is allowed to persist, it will eventually result in structural changes in the bones; and the soft tissue structures such as muscles, ligaments, and joint capsules may become stretched or shortened, or both. The element of fatigue also becomes a factor because of overactivity of the muscles which are necessary to maintain equilibrium.

Good posture can be defined, therefore, as "that state of muscular balance which affords mininal traumatization to the weight bearing structures of the skeletal system, irrespective of attitude assumed."[4]

Mechanics of the Low Back

The spinal column is balanced in the upright position by the coordinated action of various groups of muscles which, through their state of tone, oppose one another from all directions. The base supporting the spinal column is the pelvis which in turn is balanced on the femoral heads. On assuming the erect position the pelvis rotates only about 35 to 45 degrees on the femoral heads. That is, there is incomplete extension at the hip joints. This results in a downward and backward inclination of the sacrum. The lack of complete extension at the hip joints is compensated for by a position of hyperextension of the lumbar spine. Therefore, the weight bearing surface of the sacrum upon which the last lumbar vertebra rests is not horizontal but is inclined downward and forward and the body weight becomes a shearing force which produces a marked strain on the structures which support it.

From the foregoing it can be realized that the sacrum bears the vertebral column on a slope down which it tends to glide. This is prevented in part by the inferior articular processes of the last lumbar vertebra which hook over the superior processes of the first sacral. Extension is also limited by the anterior vertebral ligament and by contact of the posterior borders of the vertebral bodies or impingement of their spinous processes.[5]

The inclination of the sacrum between vertical and horizontal positions varies depending on the degree to which the pelvis rotates backward on the femoral heads. In other words, rotation of the pelvis on the femurs and extension of the lumbar spine must together accomplish a 90 degree adjustment in assuming the upright position.

The motion of the spinal column is controlled by various groups of muscles and the limits of motion is determined by the ligaments. The erector spinae group extends the column and assists in rotation when it contracts asymmetrically. The abdominal muscles control flexion and lateral bending. The muscles acting on the pelvis controlling pelvic tilt are as follows: The abdominals pull upward anteriorly and the hamstrings and glutei downward posteriorly to counterbalance the downward pull of the hip flexors anteriorly and the upward pull of the low back muscles posteriorly. These muscles all attach to the pelvis and are the chief ones responsible for the maintenance of good alignment of the pelvis in relation to the trunk and legs.

Overactivity or spasm of a group of muscles from any cause may overcome the normal tone of the opposing group with resulting deformity toward the pull of the affected muscle. Weakness of a group results in essentially the same type of deformity as spasm or overactivity of the opposing group.

Factors Influencing Posture and Effects on Low Back

The assumption of the erect position by man has been accompanied by many factors which may cause strain and stress on the structures of the low back. The commonest cause of faulty posture is muscular imbalance resulting from the habitual assumption of attitudes that fatigue and stretch muscles and ligaments. If long continued, these structures and even the bones undergo permanent adjustment to the faulty posture. That is, the body develops bad habits which by degrees gradually become worse.[6]

The most prevalent postural abnormality involving the lumbar spine is that of the lordotic or anterior pelvic tilt posture. This primary deformity is usually compensated for by exaggeration of one or more curves in the opposite direction in other parts of the column in order to keep the center of gravity of the body over the base of support. The increase in lumbosacral extension results in an excessive compression stress on the posterior part of the vertebral bodies and on the articulating facets and also in increased tension on the anterior vertebral ligament in the lumbar region. As the vetebrae deviate more

and more from their normal alignment the muscles on the convexity of the curve are stretched and lose some of their contractive power while those on the concave side are shortened and also lose contractive power. In this way an abnormal balance of power is produced.[7] The muscle imbalances most frequently associated with the lordotic type of faulty posture may be one or all of the following:

1. Tight low back muscles
2. Weak abdominal muscles
3. Tight hip flexor muscles
4. Weak glutei and hamstring muscles

As pointed out previously, the lumbosacral joint must necessarily withstand a severe shearing force because of the forward inclination of the sacrum. The strain on the facets and ligaments at that point is always great; however, the limitations vary with the individual. For example, the average housewife who does heavy work in many positions does not protect her back by proper development and use of muscles. Her posture is usually very poor with sway back and protruding buttocks which increase the lumbosacral angle and therefore the shearing force on the joint. This is followed by loss of elasticity in the ligaments which become thin and tear easily. If high heeled shoes are worn the pelvis assumes the position of anterior tilt and extension of the lumbar spine occurs in order to compensate for the anterior displacement of the center of gravity.

Also, many people sit for hours each day in chairs which are very conducive to the development of poor posture, for example, the office swivel or tilting chair. Along with this the office worker, by sitting continuously at a desk, develops short hamstring muscles, calf muscles, and hip flexors. He rides forward on the pelvis and lets it roll under him, increasing the lumbosacral angle. The paravertebral lumbosacral fascia and muscles become contracted, adding to the strain on the lumbosacral joint.[3]

Obesity is another common factor contributing to the development of poor posture. The added weight in the abdominal region shifts the center of gravity forward and in order to compensate, the upper trunk is thrust further backward. This increases the lumbar extension and adds further tension to the posterior skeletal structures.[4]

It has also been observed that prolonged housewife at the sink, is usually performed forward leaning of the trunk, as done by the with the knees completely extended and some degree of extension at the lumbosacral joint. Returning to the erect position is accomplished by further extension at that joint. Similar observations were made of individuals picking up heavy objects which were placed below the level of the mid thigh.[8]

In summary, it may be stated that the basic abnormality present in postural disorders is the same, that is, a disturbance of muscle balance. Briefly, the effects are as follows:

1. The mechanics of the bony skeleton are upset so that the relation of the joints to the line of gravity is disturbed and the natural curves of the spine become altered. This alteration results in stretched ligaments which may give rise to pain.
2. Because of the disturbances in muscular balance certain groups of muscles are subjected to stretch while others become shortened. Several important factors related to this disturbed balance should be kept in mind. First, the antigravity muscles must work harder and are therefore unable to obtain the physiological rest necessary for proper function. Second, muscular shortening interferes with the normal reflex pattern. Recent work reveals that when a muscle is shortened the muscle spindle fails to work properly; and, since detection of error in muscle tension depends on spindle activity, the central nervous system is deprived of information which is necessary for the correction of this error.[8]

Principles Underlying Treatment With Corrective Exercise

The specific objectives of exercise therapy can be summarized as follows:

1. Improvement of muscle function in maintaining corrected positions.
2. Increase in mobility of parts within the normal range by stretching of tight structures when this is necessary.
3. Obtaining a functional balance between muscle groups.
4. Development of a proper kinesthetic sense on the part of the patient so that he may recognize correct posture patterns.[9]

The erector spinae and the hip flexors are the most important extensors of the lumbosacral spine.The anterior abdominals and the glutei maximi are the most important flexors of the lumbosacral spine. Treatment is directed at reducing lumbosacral extension, thus shifting the center of gravity forward and relieving the posterior pressure at that site. To accomplish this we must actively develop the flexors of the lumbosacral spine and passively stretch the extensors.[4]

Beginning exercise routines should be restricted to those requiring a minimum of strength and coordination, especially in the acute stage. Later these are graduated to exercises of a more strenuous nature. Progression is determined by the tolerance of the patient. In order to maintain satisfactory progress the patient should also be instructed in routines which can be feasibly performed in the home. For this reason, the specific exercises instituted should be kept as simple and uncomplicated as possible.

Williams' Exercises for the Low Back

The following exercises proposed by Williams[4] are directed toward strengthening the flexor muscles of the lumbar spine and stretching the extensors. It is suggested that they be performed on a padded floor. The number of repetitions of each exercise will vary with the individual. The variation has been from 10 to 40 times. The average number employed is 15 to 40.

The first exercise is performed from the backlying position with the knees bent. The arms are then extended forward and the head, shoulders, and trunk are raised off the floor. The trunk should be flexed far enough forward so that the floor between the feet can be touched by the finger tips. This exercise actively develops the abdominal muscles. It is best that the subject does not anchor his feet. By varying the distance of the heels from the buttocks most people can perform this maneuver without stabilizing the feet.

Exercise two is performed in the same position. The feet should be flat on the floor and the heels are usually approximated closer to the buttocks than in the first exercise. The pelvis is then tilted posteriorly by an active contraction of the glutei maximi. The hands are placed on the abdomen just above the umbilicus and should hold the upper abdomen down so that flexion takes place only at the lumbosacral spine. This exercise is directed toward strengthening the glutei.

The third exercise is also done in the backlying position. The knees are brought to the chest and the hands are clasped about the legs. The knees are then pulled forcibly to the chest. The purpose of this exercise is to stretch the erector spinae and the contracted fasciae and ligaments posterior to the center of gravity at the lumbosacral level. As this is being done, flexion is being restored to the lumbosacral spine. The grip on the knees should not be released during the course of the exercise, and the thighs should be spread apart in order to avoid contact with the abdomen or chest. The knees should not be pulled over the shoulders since this results in flexion of the upper dorsal and cervical rather than the lumbosacral spine.

Exercise four is performed in the sitting position with the knees extended. The thorax is then flexed upon the pelvis and the patient attempts to touch his toes with the finger tips. This routine is directed at restoring lumbosacral flexion and stretching the erector spinae muscles and fasciae.

Exercise five is performed by extending one leg straight backward with the hip and knee of the other leg flexed to about a right angle. The thorax is flexed over the pelvis and the upper extremities are allowed to hang down. The foot of the flexed extremity should be placed and remain flat on the floor. The foot of the extended extremity should be dorsiflexed so that the weight is borne on the ball of the foot and externally rotated so that tension is applied to the anterolateral aspect of the thigh. By further flexing the forward knee the pelvis is moved up and down stretching the tight structures of the anterior thigh which limit extension of the hip joint. These are primarily the fascia lata and iliofemoral ligament. This exercise may not be indicated in all patients.

Exercise six, the "flat footed squat," is executed by placing the heels about 12 inches apart with the feet turned out at an angle of approximately 30 degrees. The heels should remain flat on the floor during the squat since rising on tip toes is compensated by extension of the lumbosacral spine which should not occur at any time during the course of the exercise. Once the feet have been placed, the spine should be curved in one total curve with the head bowed and this position maintained until completion of the exercise. The arms, elbows between knees, should be pointed toward the floor at a point about 8

inches in front of the toes and as the squat is executed the hands should touch the floor. This exercise is very effective in maintaining a muscle balance as well as preventing extension contractures of the lumbosacral spine. It is also valuable in that it can easily be done at intervals throughout the day while at work. It has the additional value of strengthening the leg muscles, especially the quadriceps group, a weakness of which is usually responsible for a person bending from the hips with the knees extended rather than squatting up and down during the course of his daily routine. An individual who maintains the ability to squat without difficulty usually encounters few episodes of acute pain in the low back.

Application of Postural Principles in Activities of Daily Living

The exercise program is essential for restoring the proper muscular balance and flexion to the lumbosacral spine; however, proper posture is maintained only by constant awareness and conscious effort on the part of the patient during the performance of his daily activities. The importance of keeping the extension of the lumbosacral spine reduced to a minimum must be impressed upon him. Unless the patient learns to maintain his improved alignment in ordinary every day activities, the exercise program will have been in vain.

Analysis of ordinary daily activities reveals that most motions consist of a few fundamental components which are combined in various ways. These include standing, walking, stooping, lifting, carrying, sitting, and reclining.

When standing and walking, the chest should be the part of the trunk which is farthest forward. The pelvis should be tilted posteriorly and the feet pointed straight ahead. Most of the body weight should be borne on the heels in order to avoid a compensatory increase in the lumbosacral angle. If it is necessary to remain in a standing position for an appreciable length of time, high heels should not be worn.[4]

In getting to a squatting position the lumbosacral spine should be flexed just prior to squatting. The squat is then completed by acute flexion at the hips and knees. A heavy load should not be lifted with the knees in extension since the work must then be done by the back muscles. The load should instead be lifted from the squatting position with the lumbosacral spine in a position of flexion. The load may be carried in front of the body at the level of the waist line if the lumbosacral spine is kept well rounded and the hips and knees are partially flexed. It should not be lifted too far above the waist line since this would necessitate an increase in lumbosacral extension and increased force on the posterior structures at that site.

Sitting should be done with the lumbosacral spine in a position of mild flexion. This is accomplished effectively if the knees are kept at a slightly higher level than the hip joints. The same holds true for the driving position. The driver's seat should be pushed far enough forward so that the knees are forced into a position higher than the hips.

Since sleeping on the abdomen increases the lumbosacral angle this position should be avoided. The preferable and most effective sleeping position is that of sleeping on the back with the knees elevated. Elevation of the knees can be attained easily by placing a roll under the mattress. In this position if the patient should turn on his side he would unconsciously draw up one or both knees and still maintain the lumbosacral flexion.

Summary

1. The commonest cause of faulty posture is muscular imbalance resulting from the habitual assumption of attitudes that fatigue and stretch muscles and ligaments.
2. The muscular imbalances most frequently encountered in the lordotic type of faulty posture are tight low back muscles and hip flexors and weak abdominal muscles and hip extensors.
3. Therapeutic exercise aims at restoring normal muscle balance and tone.
4. The application of postural principles in activities of daily living is most important for maintaining proper balance.

Veterans Hospital.

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Why Do Females Live Longer?

It is difficult to explain sex differences in mortality and longevity. These differences are being widely publicized as expectation of life at birth in the United States approaches three score years and ten. Moreover, the United States population census of 1950 was the first one to reveal more females than males—a surplus now approaching 2 million. This surplus of women is more pronounced among the higher age groups. In fact, some demographers point to the prospect of "a nation of old ladies." Lower mortality among females increasingly offsets and counterbalances the excess of male births.

Expectation of life at birth is about 73 years for white females and only 67 years for white males; in 1940 the excess for females was only four years. Expectation of life at birth is a severely qualified forecast. Currently, 1,000 white girl babies born during the year would be expected to live a total of 73,000 years if their mortality during each successive year of life were the same as now prevails. Few demographers would care to predict that age-specific mortality rates will remain unchanged, even in the 21st century, until all of these 1,000 babies have died. Likewise, the statement that 1,000 white male babies can be expected to live a total of 67,000 years, or an average of 67 years, is based upon the continuation of current age-specific mortality rates during their entire lifetime.

Whether this sex differential in longevity increases or decreases or will be greater or smaller in 1975 than it was in 1950 is a matter for speculation. Explanations of the current difference of six years are far from complete. Natural scientists are forever reminding us that the female outlives the male in most species of the animal kingdom where the question of longevity has been carefully studied. Longer life of women has been attributed to lesser pressures of living. Whereas a man has to work under greater strains in a highly complex civilization, women are aided in the release from household duties by all manner of appliances. The mortality risks of childbearing are very minor today, as attested by the precipitous decline in maternal mortality rates. Women can devote more of their time to leisurely living, especially as their children grow older.

Two sociologists, Professor Vance and Father Madigan,[1] call this social explanation of sex mortality differentials sex differences in the "styles of life." They tested this by comparing the mortality of American Catholic religious brothers and sisters, who face somewhat similar occupational hazards, do not have families, and in general are subject to somewhat similar pressures of living; that is, the differences between the sexes in the "style of life" were considered minor. These two investigators reasoned that, if they found no sex differentials in mortality in this control group, the sex variations in the "style of life" could largely explain the lower mortality enjoyed by females generally in the United States. But the nuns (sisters) had lower mortality and lived longer than their male counterparts (brothers)! Expectation of life at birth in this control group was four years, or 10%, greater for the females than for males. Since this excess of 10% in length of life for females was matched by a similar difference of 10% in favor of white females generally in the United States, the investigators concluded that "style of life" was not an explanation of lower mortality or longer life among females. Apparently the scientific explanations for longer life among females must be biological rather than social.—*Reprinted from J.A.M.A., Vol. 166, No. 17, April 26, 1958.*

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A Progress Report on Wisconsin's Nursing Homes

By VINCENT F. OTIS *
Madison, Wisconsin

EIGHT years ago the potential importance of nursing homes caring for the state's aged and chronically ill was coming to be recognized. There were many homes which were providing a high level of care and which had acceptable facilities. There were too many others, however, which lagged far behind. With important building code requirements often violated, safety and welfare of patients were endangered. Crowded conditions were common in too many homes and good housekeeping was often lacking. There was danger of misusing drugs and medications. Very little recording was done on patients' charts.

The Wisconsin Legislature in 1951, recognizing the urgent need for regulating these nursing homes, adopted the licensure act and provided for an advisory committee appointed by the State Board of Health to recommend standards for their maintenance and operation. The committee's recommendations when adopted by the Board have the effect of law and must be met substantially to retain a license.

The growing need for nursing homes and homes for the aged resulting from the increasing number of senior citizens and the shortage of adequately trained personnel to render either nursing or personal care has required that the rules adopted be practical ones in view of existing conditions. It is also important that there be steady improvement so that all homes will eventually attain standards reached by the more progressive homes. The advisory committee, therefore, adopts recommendations which exceed the minimum standards so that guidance can be given toward gradual improvement. Reports of official personnel visiting the existing homes show that progress is being made.

New homes which are now being built are frequently one-story structures or built of fire-resistive materials in contrast to the older homes which were of frame or ordinary construction, not fire-resistive. Public health engineers visit every proposed nursing home prior to licensure to assure the public that safety, health, and sanitation rules will be met and so promote the welfare of patients to be sheltered therein.

Adequate financing of new facilities continues to be a real obstacle. Federal grants-in-aid have made it possible to construct or program seven nursing homes during the past five years at Tomah, New Richmond, Durand, Platteville, Hillsboro, Prairie du Sac, and Berlin. But for every application approved, ten to twelve are not approved due to the limited aids which permit about one 50-bed project for the entire state each year. One source of funds which is increasing lately is from estates and bequests. Several communities have already benefited from the generosity of civic minded persons concerned with the problems of our aged and chronically ill.

The greatest need now facing those who operate nursing homes is for registered professional nurses and licensed practical nurses to render care, or supervise nursing care needed by an estimated 40 per cent of the patients. Steps are being taken to alleviate this. Nurses from the Board of Health are now conducting one day institutes on a local area basis to train some of the lay personnel in basic procedures desired in the care of the long term chronically ill person. This is in addition to visits made by these same nurses to determine compliance with minimum standards. In many areas the visiting nurses associations are becoming increasingly concerned with the problems of long term illness and offer service to nursing home patients. County medical societies have

*Director, Division of Hospital and Related Services, Wisconsin State Board of Health.

appointed geriatric committees to advise and consult with local agencies pertaining to medical aspects of aging including the care of those in nursing homes. An experimental program of rehabilitation is presently being carried on in the Green Bay area to restore as many chronically ill persons as possible to self care and perhaps return a few to their own homes again.

While progress is being made, a great deal remains to be done before the average citizen in Wisconsin can be proud of the manner in which society is taking care of the increasing number of aged persons becoming mentally or physically infirm, or chronically ill, who must look to facilities other than their own.

Henry G. Rudner, Sr. Award Contest

The American College of Gastroenterology takes pleasure in announcing the establishment of an award contest for the best unpublished paper on research in gastroenterology or an allied field. This award is to be known as the Henry G. Rudner, Sr. Award, honoring Dr. Henry G. Rudner, Sr. of Memphis, Tenn., chairman of the Research Committee of the American College of Gastroenterology and former chairman of the Board of Governors of the organization.

This contest will be open to all those possessing the degree of Doctor of Medicine from a recognized medical school or university.

All papers submitted must represent original work in gastroenterology, or an allied field, and must not have been previously published except for abstracts or short preliminary reports. It must not have been previously presented on the program of any scientific meeting.

The contents of the papers can be clinical or basic science. Clinical papers must not be case records, but controlled clinical work.

The length of a paper is no criterion for originality or value.

All entries for the 1959 award must be typewritten in English, double-spaced on one side of the paper and submitted in six copies.

The winning entry will be selected by the Research Committee of the American College of Gastroenterology and the award will be made at the Annual Convention Banquet of the College, to be held in Los Angeles, California, in September of 1959.

The prize will be an award of $750.00 plus an additional $250.00 for traveling expenses to present the paper at the 24th Annual Convention of the College.

The paper selected for an award becomes the property of the American College of Gastroenterology and the decision of the judges will be final. Should none of the papers submitted meet the standards set by the committee, the College reserves the right to withhold the making of any award.

All unpublished entries must be received no later than June 1, 1959, and should be addressed to: the Research committee, American College of Gastroenterology, 33 West 60th St., New York 23, New York.

Poison Control . . .

(continued from page 114)

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

Amphotericin B, an Effective Antifungal Agent

By HELEN A. DICKIE, M. D.
Madison, Wisconsin

SINCE THE discovery of penicillin and the subsequent antibiotics which have been so successful in the control of a majority of the bacterial infections, the hope has existed that a similar substance might be found which would be effective against fungi. Such an agent, amphotericin B (Fungizone®), exhibits considerable promise and is now available. This material was prepared from a species of Streptomyces found in a soil sample from Tembladora on the Orinoco River in South America. *In vitro* tests revealed its effectiveness as an antifungal agent against a large number of pathogenic and nonpathogenic organisms. Experiments with animals similarly demonstrated its *in vivo* activity after intravenous or intraperitoneal administration. A comparable level of activity was not realized when the oral route was employed. It appears that absorption of the drug from the gastrointestinal tract is minimal; however this drawback may be overcome, as it was with penicillin, by increasing the dose.

At present amphotericin B is available as a sterile, lyophilized powder which is prepared for intravenous use by reconstitution in a 5% solution of dextrose, rather than saline which causes precipitation of the antibiotic. A solution containing 1.0 mg. per 10 ml. is administered by slow intravenous infusion over a two to six hour period. The recommended initial dose is 0.25 mg./kg./day which is gradually increased to .5 to 1 mg./kg./day. A dose in excess of 1.5 mg./kg./day is dangerous. Solutions of the drug are too irritating for intramuscular use except in unusual circumstances when 20 mg. may be dissolved in 2 ml. of 5% dextrose and injected into an area which has been locally anesthetized. Intrathecal injection of 0.5 to 1 mg. of the drug dissolved in water has been used.

Amphotericin B frequently causes chills and fever which tend to decrease in severity with subsequent administration. Occurrence of headache, nausea, and vomiting indicates toxicity and a reduction of dosage should follow. Thrombophlebitis, a frequent problem, can be circumvented by employing more dilute solutions, addition of heparin, and slower rates of infusion. Increases in the blood urea nitrogen and nonprotein nitrogen have been noted without other evidence of renal dysfunction. Withholding the drug for a few days usually results in the return of these values to normal.

Reports of the clinical effectiveness of amphotericin B are still limited in number since many of the fungus infections are difficult to evaluate because of their erratic courses. Several observers have stated that cryptococcal meningitis can be controlled. Smears and cultures of spinal fluid have been rendered negative and the patients have remained well. Treatment should be instituted as soon as possible after the diagnosis has been established. In view of the chronic nature of the disease, a minimal period of two or three weeks treatment is recommended, the drug being administered daily or every other day. Intrathecal administration is to be considered in seriously ill patients.

Cutaneous lesions of blastomycosis seem to respond satisfactorily to amphotericin B. Healing starts promptly and in several patients we were unable to demonstrate the *Blastomyces dermatitidis* after the first week of treatment. It is the drug of choice since its recognized toxicity is less than that of

either stilbamidine or hydroxystilbamidine. Whether drug resistance and relapses will occur is not known. For eradication of chronic foci, e.g. large abscesses, pulmonary cavities, surgical intervention, in conjunction with drug therapy, is to be considered.

Chronic disseminated forms of histoplasmosis have been reported to respond well to treatment with amphotericin B. The acute epidemic types of pulmonary histoplasmosis have also been treated with prompt subsidence of fever. The effectiveness of antifungal therapy here is not certain since the majority recover and remain well without treatment. It may be helpful in those patients in which the illness is severe and prolonged. However, the course varies so widely that any clear cut information will be hard to secure in this type of histoplasmosis. Although sputum conversions have been reported in the chronic cavitary pulmonary form, development of drug resistance might be anticipated.

The reported effectiveness of amphotericin B in infections with *Coccidioides immitis* are not uniform. In one patient treated at the Veterans Administration Hospital in Madison, a severe empyema with a bronchoplural cutaneous fistula responded very promptly to treatment. The organisms, which had been easily demonstrable, were absent at the end of a week of therapy. Marked improvement occurred and a pneumonectomy was performed without evident recurrence of the disease and the patient has remained well for one and a half years. In another patient with a disseminated infection the complement fixation tests became negative for the first time since the recognition of her disease in 1952. No draining sinus tracts were present at the onset of therapy so the effectiveness of the treatment is less certain.

The use of amphotericin B in several patients with a generalized *Candida albicans* infection has been reported to have resulted in prompt improvement. In actinomycosis and nocardiosis sulfadiazine and penicillin are still the drugs of choice. To date *in vitro* studies suggest that amphotericin B is quite ineffective against these organisms.

At this time amphotericin B is an antifungal drug of considerable promise. Toxic reactions, while bothersome, are not serious. Its use is recommended in the treatment of cryptococcal infections, blastomycosis, disseminated histoplasmosis, generalized candida infections, and cocoidodomycosis. The length of therapy, the dosage, the development of antibiotic resistance, and delayed toxicity are still uncertain. However, for the first time we have a drug which seems to be quite effective against a large number of pathogenic fungi.

1959 Mississippi Valley Medical Society Essay Contest

The attention of physician-medical writers is called to the Mississippi Valley Medical Society Annual Essay Contest. Any subject of general medical or surgical interest including medical economics and education may be submitted providing the paper is unpublished and is of interest and applicable value to general practitioners of medicine. Contributions are accepted only from physicians who are members of the A.M.A. and who are residents and citizens of the United States. Manuscripts must not exceed 5000 words and be submitted in 5 complete copies, in manuscript style. The winning essay receives a cash prize of $100.00, a gold medal, and a certificate, also an invitation to address the annual meeting of the Mississippi Valley Medical Society. (Held at time and place of the American Medical Writers' Association; 1959 meeting, St. Louis, Sept. 30, Oct. 1, 2) The Society may also award certificates of merit to physicians whose essays rate second and third best. Essays must be in the office of the M.V.M.S. Secretary not later than May 1, 1959. Winning essays are published each year in the January MISSISSIPPI VALLEY MEDICAL JOURNAL (Quincy, Ill.). Further details may be secured from Harold Swanberg, M.D., Secretary MVMS, 209–224 W.C.U. Building, Quincy, Illinois.

Polio Foundation Announces Expanded Health Scholarship Program

The National Foundation (formerly the National Foundation for Infantile Paralysis) has announced that scholarships, each amounting to $500 a year for four years, will be made available in the fields of Nursing, Physical Therapy, Occupational Therapy, Medical Social Work and Medicine.

Three scholarships will be awarded annually to Wisconsin students on the basis of financial need and scholastic achievement.

Editorials

THE MEDICAL PROFESSION AND THE INDUSTRIAL COMMISSION

It is perhaps a foregone conclusion that all administrators of workmen's compensation laws have their respective problems in determining many medical issues. Perhaps 98 per cent of all claims processed by administrators of workmen's compensation laws involve some degree of medical issues. For purposes of brevity, these issues can be listed as follows:

1. Was the conceded or alleged injury responsible for producing any given type of pathologic condition?
2. What is the extent of temporary total disability resulting from the injury?
3. What are the nature and extent of the resulting permanent disability?
4. To what extent are additional medical care and treatment needed?

Almost all cases coming before the commission for formal hearing involve a controversy regarding medical opinions. These different opinions may exist in any one or all of the forenamed categories. To render adequate justice in disposing of such claims it is necessary that a person have a reasonably good knowledge of medicine and human anatomy. Some of this information can be obtained from medical textbooks, and perhaps the most valuable information can be secured through personal discussions of the issues with competent medical men.

Perhaps the most difficult problems to resolve are those involving conflicting medical testimony on causal factors of either a conceded or alleged injury. I have in mind the development of such conditions as periostitis, osteomyelitis, malignant conditions of either the soft tissues or the bony structure, mental conditions, and cardiac involvements.

I am certain that most if not all administrators at times become confused in attempting to make valid decisions in these cases. As a rule, these disputes concern findings of fact as distinguished from issues of law. In most jurisdictions, a finding of fact made by the administrative agency results in final adjudication, with testimony in the record supporting the finding made. On the other hand, the appellate courts do not hesitate to reverse administrative agencies on those cases involving issues of law. Further complications arise over securing a true history of what the involved person was actually doing at the time of the injury and the symptoms immediately following the conceded or alleged incident. These histories often are distorted by both lay and medical witnesses.

Doctors must realize the absolute need for securing a detailed and accurate history of either the alleged or conceded injury and the symptoms which followed its occurrence. This information, whether secured by a doctor or lay person investigating the claim, becomes materially important in the final determination of many claims. We know that histories are extremely important to either examining or attending physicians in making a proper diagnosis and in determining the nature of the existing pathologic conditions and whether or not these conditions can be related to the injury.

The life and duties of an administrator could be made far more pleasant if all medical men were entirely honest in their testimony and expressed opinions. This statement is not intended to imply that doctors as a rule are dishonest. Their views at times seem to be somewhat influenced by whether they are generally known and accepted as either plaintiffs' or defendants' doctors. Continuing retainers for defendants bring medical men in contact with some unscrupulous plaintiffs or claimants who are attempting to obtain benefits where they are not due. This misrepresentation can be found in the histories given by plaintiffs, perhaps a natural tendency to exaggerate or magnify their complaints, and extends to unquestionable malingering. Likewise, a few insurance adjusters and employers attempt to take undue advantage of claimants.

Fortunately, the majority of claimants make honest claims for compensation; this is also true of the majority of both the attending and examining physicians. Normally there is no valid reason for anyone to distort the actual or prevailing facts, and thus there is no justification for material differences on medical issues.

The Wisconsin commission has attempted to eliminate these problems insofar as possible. Progress in this regard has been accomplished only through unselfish and outstanding support from qualified medical men in our state. With the assistance of medical advisory committees, our commission has set up certain standards and guides for some of the medical problems.

Assisted by a group of eye specialists, the Wisconsin commission has developed a medical questionnaire on eye disability. The attending physician on all eye disability cases is required on discharge of the patient to fill out one of these questionnaires, answering all questions relating to the nature, extent and history of the injury and the symptoms following the injury, specifically mentioning all existing pathologic findings. This same advisory committee developed a formula whereby the existing pathologic condition can be transposed into percentage loss of vision in cases of permanent disability.

Another medical committee assisted the commission in designing what is known as the relative

permanent disability schedule. This formula relates to all extremities of the body, including the various digits at all of the involved joints. Designated percentages of disability are allowed for certain restricted movements of the involved extremity or joint.

The last schedule developed relates to occupational loss of hearing. The advisory committee consisted of five otologists, who devised the formula in a series of seven lengthy meetings. Adopted in 1955, this formula has been requested by other states. The problem of impaired hearing resulting from occupational noise is a common one to most states and at best is difficult to determine. Any or all of these formulas can be amended by the commission when circumstances indicate such action is necessary.

Any new formula is given wide publicity following its acceptance by the commission. A year or two of use is sometimes necessary before the formula and its application are properly understood. It is surprising to observe how these various medical formulas tend to lessen the number of controverted claims coming before the commission. For example, prior to the adoption of the relative permanent disability formula, it was common to have extreme variations in the estimate of permanent disability for an ankylosed knee. Medical estimates varied anywhere from 15 to 100 per cent permanent impairment of the leg at the knee. According to the stipulation in the adopted formula, the allowance for a knee ankylosed at 170 degrees represents 40 per cent permanent impairment of the leg. We know that all knee injuries do not result in ankylosis, but the established guideposts assist materially in determining other degrees of impaired motion in the knee.

I am sure that every administrative agency of workmen's compensation recognizes its responsibility with respect to the prompt payment of compensation. Wisconsin has established an enviable record in this regard by having prompt payment of compensation made in 95 per cent of the total claims occurring in the state. Such a result can be obtained only through the cooperation of all parties interested in claims handling. This involves insurance representatives, self-insured employer representatives, medical men and attorneys. It requires prompt and specific medical reports from the doctors concerned. As soon as possible, the doctor should attempt to decide when the claimant will be able to resume any form of work. In some cases it is desirable to have a person resume work on a partial basis to strengthen and restore the injured member or portion of the body. Any major permanent disability should not be determined, if possible, until at least three months following the injured person's return to work. It is desirable that doctors estimate approximately when compensation payments should be discontinued and work resumed. In Wisconsin, we have been exceptionally fortunate in receiving cooperation and assistance from members of the state medical society.
—R. G. KNUTSON, *Chairman, Wisconsin Industrial Commission*

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Wanted! Photos of Wisconsin Physicians

At Work

In Research and Teaching

In History

In Public Service

At Play

Make your plans now to send a photo of yourself or a colleague to the State Medical Society for entry in the annual Wisconsin Physicians Photography Exhibit to be displayed at the annual meeting in May. Photos will be placed in one of five classes which are listed at the left. This is a project of the Society's Charitable, Educational and Scientific Foundation, Inc., in cooperation with the Section on Medical History. For information about the exhibit and a set of rules, write: State Medical Society, Box 1109, Madison 1, Wisconsin.

The President's Page . . .

Are We Losing Our Independence as a Profession?

THERE ARE INDICATIONS that the medical profession, both nationally and in the various states, is putting forth an even more vigorous effort than in the past for constructive health legislation. This is good. Medicine must take the lead in public health, particularly in the face of stronger efforts among the cultists and quacks on the public health side and among those who would desire strong government control on the socio-economic side.

There are some who feel that the national legislative scene now poses the greatest threat to free enterprise and the voluntary way of life since the era of the New Deal in 1932. At the least such reports should alert the medical profession to the very real dangers of gradual and piecemeal loss of its freedom as an independent profession.

We as doctors have faced many attacks on our freedom, especially during the years from 1938 to 1953. With concerted effort these attacks were repulsed. Since 1953, however, most doctors have complacently sat back on their collective haunches, secure in their belief that medicine had won.

But has it? The original Wagner–Murray–Dingell bill is becoming law, piece by piece. The Social Security Act has been extended to pay disability benefits to those over 50 with the fact of disability to be established by government regulations. The Forand bill would give "free" hospitalization and medical care to all over 65. Should this bill become law it would only be a question of time until all the citizens would be included. Government control of medicine and its allied fields would then be complete.

I believe that one of the reasons for this inexorable trend is the apathy of the medical profession itself, collectively and individually. In spite of the fact that the 85th Congress did not pass Forand-type legislation, medicine used very little of its legislative potential. We could do much more.

First, every doctor must familiarize himself with the issues facing medicine today and then make his voice and influence known to his state and national representatives. Second, we must learn to live more easily with "prepayment" medicine. It is here to stay but it must be guided in a proper direction. We must deliver to our patients the best possible medical care at a cost that can be afforded. Third, grievance committees must get tough with the fee-gougers and chiselers who disgrace the profession of medicine. It is this small minority who furnish the ammunition for legislation such as the Forand bill. Fourth, we must revitalize our organized medical societies on a local as well as a national level. Membership should be sought after and not avoided as is true in many instances. Fifth, young physicians who are embarking upon their careers must be oriented as to the controversial issues facing the practice of medicine today, for they and their patients will be most affected should the principles of free medical practice be lost.

And finally, we must realize that when a government takes over anything, it takes it all. As Dr. David Allman once said when he was president of the American Medical Association, "Any government that is big enough to give a man anything he wants, is also big enough to take away from him everything he has."

William B. Weisbrod, M.D.

Section on Medical History

As January drew to a close the State Historical Society held its annual Board of Curators business meeting at State Medical Society headquarters.

Conscious of the role that medicine has played in the history of Wisconsin, the SMS used the occasion to unveil three special exhibits.

One is a pictorial history of the SMS building site. On a large map of the area there are photographs or sketches going back to 1855 when the Lakeside Water Cure occupied a spot just east of the present site. There are pictures of the old Monona Assembly Grounds where, in the 1880's, thousands flocked for the summer chautauquas that once featured silver-tongued William Jennings Bryan. In the 1920's the Seventh Day Adventists had a combination sanitarium and hospital just a stone's throw away.

Another exhibit contrasts the past and present. The first hospital in Wisconsin, part of the Fort Howard military establishment in 1816, is pictured. Alongside is a photo of today's modern Wisconsin General Hospital. There is a 1903 picture of an anatomy class beside a 1959 surgical theatre. And an 1890 pharmacy is depicted with the wondrous drug store of today.

Resting together are volume II of the proceedings of the Wisconsin State Medical Society published in 1857 and volume 57, the December, 1958, issue of the *Wisconsin Medical Journal.*

Many of the collections which the SMS has gathered for years have been refurnished, mounted and put on display in the Council Room. There is an 80-year-old lung pad guaranteed to cure asthma, bronchitis and tuberculosis, made by the Only Lung Pad Co., Detroit. An 1854 mortar and pestle sit beside eight drug containers filled with such ingredients as quince seeds, rhubarb powder and asafetida powder.

These exhibits of the historic past tend to add that fourth dimension, Time, to the new State Medical Society headquarters.

* * *

The gavel used to open and close meetings of the Council of the State Medical Society has special significance—it was a gift from the Douglas County Medical Society, and was made by a member of the society.

Wood for the gavel came from the oak keel board of the old Algonquin, the first ship to sail Lake Superior. This ship was built just two years after establishment of the state society in 1841.

Dr. John A. Baird, of Superior, made the gavel, and it was presented to the state society in the fall of 1930.

Wherever the Council goes, so does the gavel, no matter if it's Milwaukee, Land O'Lakes or Madison.

A trim schooner, the Algonquin was made at Black Rock, Ohio, in 1843 and later completely outfitted there. She carried two boom sails, two top sails and two jibs. Her overall length was about 70 feet and her width 20 feet. Light, she drew only two feet of water and six loaded. Her crew called her a fast sailer, a staunch and seaworthy craft.

The Algonquin was built by a fur company for its coast trade. Her tonnage was rated at 70 and she carried a four-man crew.

Her first stop in Wisconsin was made in 1845, at La Pointe, and she continued onto trading posts at the present sites of Superior and Duluth. The cargo consisted of furs, wild rice, maple sugar and fish. Except for the small Mackinaw sail boats used by the early voyagers and fishermen, the Algonguin was the only craft on Lake Superior.

During the 1850s, her captain was Albert Angus who lived in Superior. In the 1860s, steamboats were able to come through the newly-constructed Soo locks, and they gradually absorbed the schooner trade.

About 1874, the vessel was laid up at Superior and because of lack of use and attention, became filled and water logged. Her rigging was removed and she sank to the bottom. In 1884, she was hauled onto shore for the purpose of utilizing the timber in her keel and hull in building a steam yacht. However, within a week or two, she was cut to pieces and carried away by curio hunters.

Many articles of furniture, still revered, were made from the timber. One hunk of wood came into the possession of Doctor Laird and from it, he carved the gavel.

A member of the State Medical Society from 1906 until his death in 1942, Doctor Baird had been graduated from Trinity Medical College, Toronto, in 1888, and licensed in Wisconsin in 1904.

THE MEDICAL FORUM

STATE

Legislation

As the 1959 Legislature convened in Madison early last month, the changes wrought by the upset November elections were more striking than ever. Gone was many an old familiar figure, to be replaced by the new.

But while freshman legislators walked the marble capitol corridors in droves, the problems they and their veteran colleagues faced were as old as government itself: How to provide more governmental services, and how to pay for them.

After a slow start since January 14 when the legislative session formally opened, house hoppers suddenly became filled with measures affecting medicine and public health.

Drastic Changes. The first three measures introduced in the Senate proposed drastic changes in the state mental health program. Bill 1–S would replace the present interdepartmental commission on mental health with a state mental advisory board of nine members. It would review all state mental health programing and operate through an executive staff.

Bill 2–S would transfer authority for the development of child guidance clinics from the State Board of Health to the Department of Public Welfare. At the same time it would provide state aid to local communities (40%) to support mental health services. Bill 3–S would appropriate $500,000 for construction of a residential treatment facility for emotionally disturbed children under jurisdiction of the Department of Public Welfare.

The State Medical Society believes the aid to community mental health services could be provided better under authority of the State Board of Health where this program has operated for the past 17 years. While supporting the principle of Bill 3–S, the Society feels a closer tie-up with the University Medical School is necessary for the proper development of a treatment center for disturbed children.

Healthwise, the legislative scene was relatively quiet until the week of February when two bills relating to chiropractic and one concerning hospitals and the practice of medicine were introduced.

Chiropractic Opposed. Bill 133–A would provide chiropractic care under workmen's compensation laws. The bill was scheduled for hearing a week after introduction, and the State Medical Society was opposed.

Bill 154–A, introduced by two Democrat and two Republican Assemblymen, concerned chiropractic training. It would require that after July 1, 1964, an applicant for chiropractic license must show evidence of graduation from a chiropractic school determined by the registrar of the University of Wisconsin to be substantially equivalent in quality to the U.W.'s faculty and teaching methods. The State Medical Society will support this bill when it comes up for hearing.

Bill 129–A would permit most hospitals exemption from the "fee splitting" law by allowing them to hire anesthesiologists, radiologists, physiatrists and pathologists and charge patients directly for medical services rendered by these specialists. All other physicians' services might also be included because the bill proposes similar arrangements for any other employee of the hospital.

STATE CAPITOL

Hoppers suddenly became filled.

Among the recommendations for new legislation were those of the Wisconsin Welfare Council. The 77-year-old Council is composed of both professionals and laymen, public and private welfare agencies. It acts as a state-wide coordinating and planning body in all welfare matters.

Said the Council in the preamble to its 1959 legislative platform: "Public welfare, as related to social services, is interwoven with consideration for the general welfare. Public welfare must be viewed in the context of a healthy economy and with a genuine concern for the general welfare."

Some specific Council recommendations:

Public Assistance. A Wisconsin definition of *total and permanent disability* closely parallel to the federal definition to insure that eligibility for the needy disabled is based upon "employability" rather than on amount of physical or medical care required.

Social Services and Institutions.

1) Residential treatment center for emotionally disturbed children along the lines favored by the Legislative Council's Mental Health Committee (and the State Medical Society).
2) State aids to county mental hospitals, administered on state-wide standards.
3) State aids to community mental health facilities as recommended by Legislative Council's Mental Health Committee.
4) Funds and personnel to help released patients become restablished in communities.
5) Where voluntary institutions exist as alternatives to state institutions, a purchase-of-service arrangement similar to that used for foster homes.

Public Health. Steps to secure city–county (or county-wide) public health services, staffed according to accepted national standards, and (a) a Legislative Council study of problems to meet public health needs; (b) consolidation of smaller local public health jurisdictions in townships and villages of populations under 1,000 into county health commission.

The guiding principle for public health, stated the Wisconsin Welfare Council, was that rural communities were entitled to high quality services comparable to urban communities.

"It is a state responsibility to foster effective communication to local health authorities, to motivate effective public health efforts, to strengthen local health resources," concluded the Council.

GRANDVIEW CLINIC
1707 Main Street
La Crosse, Wisconsin

January 6, 1959

Mr. C. H. Crownhart
The Wisconsin Medical Journal
Madison, Wisconsin

Dear Mr. Crownhart:

In reading the recent Supplement regarding the Stevens Point special session, my vote on the final recommendation of the Reference Committee was incorrectly recorded as Yes instead of No as I had voted.

Since I was about the only delegate voting in the negative outside of Milwaukee County it might have been felt that I had made a mistake in the midst of the confusion that existed at the meeting. On the contrary I fully understood the issues. I voted No because I felt that this meeting, held at considerable expense to the State Society (which means us) as well as the personal expense to each attending delegate, had accomplished little or nothing and in fact had made matters worse. I felt that the final motion as passed was no solution and that the issue before the house, being the most important business the Society had to settle in 1958, should have kept the house in session until there was at least some evidence of meeting of the minds.

No one group can be blamed for this failure. There was no evidence of "give and take" from any corner. I feel that other groups were as much the problem as the one group often blamed. Why should Wisconsin Medicine suffer for the animosities of a couple of groups? The whole matter was an unrealistic approach to an exceedingly important matter.

Since I have already indicated my vote and views in my report to the La Crosse County Society will you kindly publish this letter and correction in the next issue of the Journal.

Sincerely yours,
(signed) JOHN J. SATORY, M. D.

STATE MEDICAL SOCIETY
330 E. Lakeside Street
Madison, Wisconsin

January 15, 1959

John J. Satory, M. D.
Grandview Clinic
1707 Main Street
La Crosse, Wisconsin

Dear Doctor Satory:

Mr. Crownhart received your letter just as he was leaving for Superior for a series of talks. He asked that I reply so that you might have a prompt answer.

You are quite right that your vote on the final recommendation of the Reference Committee is incorrectly recorded. This came about because the transcript of the stenotypist indicated that you had voted yes on the final vote. A check against the manual recording of the vote by Mr. Crownhart reveals that he had recorded you properly as having voted "no".

We will certainly do our utmost to correct the situation and we will be happy to publish your letter and correction in the next issue of the Journal.

Sincerely Yours,
(signed) EARL R. THAYER
Assistant Secretary

A Correction . . .

An error in recording the votes taken at the Stevens Point special session of the House of Delegates was carried into the stenotypist's transcript, then later into the December issue of the *Wisconsin Medical Journal.* An exchange of letters (see box) has led to a correction of the official records.

Era of Aging

In Wisconsin, some 370,000 people are in a growing class of Senior Citizens, who are 65 years old or older. They represent 9.1% of the state's population, a figure which is a shade higher than the national average of 8.4%.

Such statistics are heartening. Yet each addition to the average life span has also brought a multiplication of the problems of the aged. Medical Science, well aware that it is primarily responsible for the advance of longevity, has long been in the forefront of several national and state conferences on the growth of the elderly population.

Recently, the Fond du Lac County Medical Society brought the matter down to the local level by initiating a community-wide program on the "New Era of Aging."

Representatives of 38 organizations and groups in the city and county joined physicians in mid-December for a round table discussion of the problems involved in the aging process and suggestions which can be carried out to meet the needs of the elderly.

Sparkplug. The sparkplug of the event was Dr. A. M. Hutter, Chairman of the County Medical Society's Division on Geriatrics.

Ten basic needs for older individuals were cited by Doctor Hutter:

1. A balanced diet.
2. Elimination of waste products.
3. Rest, with adequate rest of the mind and body every 24 hours.
4. Recreation.
5. A sense of humor.
6. Emotional control.
7. Companionship.
8. Maintenance of a sense of pride in one's job.
9. Participation in community affairs.
10. Preservation of an open mind.

Doctor Hutter said that "arbitrary assignments of older persons

to inactivity cannot be tolerated in a society which places a premium on individual work and dignity. We cannot isolate the aged. Labor and industry should evaluate their support of arbitrary retirement based on chronological age. All groups must re-orient their attitude toward the aging process and opportunities which the new status of age provide."

Dr. D. W. McCormick discussed disabilities arising among the older residents from bone and joint diseases. Dr. Harvey K. Guth discussed the genital urinary diseases and disturbances of calcium metabolism.

Rural Relation. Dr. W. C. Wojta described changes in vision and hearing and discussed high blood pressure, arteriosclerosis and diabetes. Dr. James Haberman of Mt. Calvary talked on the problems of rural communities in relation to the aging. He emphasized the need to prevent and arrest the causes of degenerative diseases.

Others discussed the role of nutrition and religion in healthy living for older citizens.

Doctor Hutter stressed the necessity for aging programs that are "health-oriented and not disease impelled." He said that exercise, intellectual activity and mental equanimity as a blueprint for continued good health.

Emergency

Physicians have been worried for some time about their patients who are on long-term anticoagulant therapy.

In an emergency, such as an accident that would induce bleeding, these patients are in eminent danger. Proper first aid treatment requires knowledge that anticoagulants are present.

Recently an emergency identification card (see cut) to protect such patients was made available to state physicians.

Developed by the Wisconsin Heart Association, the wallet card points out that the bearer "is being treated with anticoagulants which slow down clotting of blood".

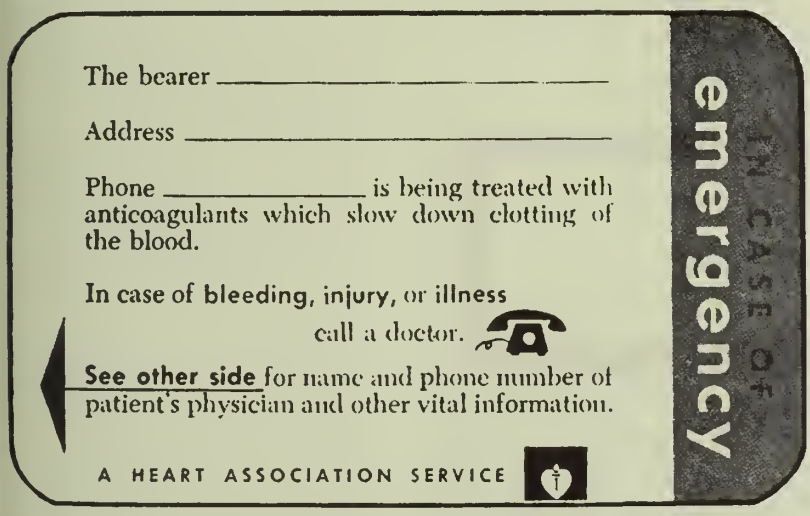
In case of bleeding, injury or illness, the card states to call a doctor, since the patient may require an antidote.

Sample. Space is provided for only the patient's name, address and phone number but for those of his personal physician as well. Blood type and anticoagulant prescribed may be recorded.

Designed at the request of physicians, the I. D. card has the approval of the Committee of Prothrombin Determinations of the American Heart Association.

The Wisconsin Heart Association, in making the card available to doctors, is calling it to the attention of dentists, hospital emergency room personnel, nurses, police and others who must often handle emergencies.

Samples of the identification card may be obtained by physicians from the Wisconsin Heart Association, 205 W. Highland Avenue, Milwaukee 12.



IDENTITY CARD FOR EMERGENCY USE

The patient is in eminent danger.

DR. E. W. PAWSAT

The siren wailed.

Civil Defense

At exactly 8:31 P. M. Tuesday evening, January 20, the air raid sirens in Fond du Lac raised their fearful whine. Into the wintery night sped civil defense volunteers, city and county police, auxiliary police, doctors, nurses and hospital personnel. Ham radio operators manned their mikes, and the city crouched on the alert.

Minutes after the first siren wails, ambulances, hearses and other emergency vehicles were loading victims for transfer to St. Agnes Hospital. Within 15 minutes, 31 doctors of various medical teams, along with 75 nurses and other personnel who had been summoned, were at the hospital.

By 8:40 P. M. 36 victims had been transported to St. Agnes and were receiving treatment. Coordinating the operation at the hospital were Sisters M. Wilfreda, M. Josephine, M. Leo, all CSA, and Dr. E. H. Pawsat.

"I can't tell . . ." All this, on a near-zero night, was fortunately just a mock catastrophe exercise for the area of Fond du Lac. The "victims" were 36 Boy Scouts who played their roles well. (So realistic was the test that one Scout, when asked his name by hospital officials, replied: "I can't tell, I'm dead.")

The test turned up certain hitches that would have to be ironed out in the future, such as the fact that the sirens could not be heard in some parts of the city. But the 250–300 persons who took part in the mock disaster had gained immeasurable experience in the only way they could short of war.

The Fond du Lac *Commonwealth Reporter* concluded: "St. Agnes Hospital and the city's civil defense organization is capable of handling a major disaster."

NATIONAL

Conference

Plans are currently under way for a national conference on the health problems of the aged to be held in the spring of 1959 under the sponsorship of the Joint Council for the Health Care of the Aged.

The Council, based in Chicago, is supported by the American Medical Association and the national associations of dentistry, hospitals and nursing homes.

This conference will provide the basis for more effective joint planning on the part of those who are the principal surveyors of health care for the aged, according to officials of the Council.

Dr. Gunnar Gundersen of La Crosse, president of AMA, is a director of the Council. The Council's objectives are to identify and analyze the health needs of the aged, appraise available health resources for the aged, develop programs to foster the best possible health care for the aged, foster effective methods of payment for the health care of the aged, and foster health education programs of the aged.

Polio Protection

Recommendations

1. **Those Children and Adults who have not had a 4th (BOOSTER) Polio Immunization within 3 years are urged to receive this prior to the next Polio Season.**
2. **It is again recommended that all Children and Adults who have not had their INITIAL series of Polio Vaccine be immunized promptly!**

Polio Committee

Fond du Lac Medical Society

With less than half (about 45%) of the eligible Americans protected against polio, the AMA is launching a national campaign, starting immediately, to push wide-spread vaccination. The above public service advertisement, from Fond du Lac's *Commonwealth Reporter* on Feb. 5, is a commendable effort of the Fond du Lac Medical Society to encourage public participation.

Health Dollar

Americans today are spending more for health care than ever before in history.

A recent report from the Health Information Foundation pointed out that spending for hospital care, physicians' services, drugs, and other health measures in 1957 took 5.3¢ out of each consumer-expenditure dollar. This is a 40% increase over the 1929 figure of 3.7¢.

Almost unnoticed in the past three decades has been a gradual redistribution of the health care dollar. Today, proportionately more of the dollar is being spent than ever before on hospitals, health insurance, ophthalmic products and orthopedic appliances.

Physicians have gotten a smaller share of the health care dollar. During the 1947–57 period the amount paid to physicians rose from 1.2¢ out of every dollar to 1.3¢. But at the same time hospital services rose from 0.8¢ to 1.4¢ and drugs from 0.8¢ to 1.1¢.

The following are actual amounts spent per average person on health care, along with percentages in parentheses:

	1929	1957
Physicians	$7.89(33%)	$21.93(24%)
Hospital	3.31(14)	23.07(26)
Insurance	.89(4)	6.32(7)
Drugs	5.00(21)	18.50(21)
Dentists	4.00(16)	10.00(11)
Other professional Services	1.50(7)	4.50(5)
Glasses, Appliances etc.	1.00(4)	6.00(7)
Total	$24.00(100%)	$89.00(100%)

Four trends are cited by the Health Information Foundation as contributing to the high quality of modern health care; at the same time these have added expenses to the consumers:

Average annual number of patient days in general and special hospitals in the U. S. rose from 0.88 in 1935 to 1.25 in 1956.

During that time the number of births in hospitals increased from just under 800,000 to about 3.8 million a year.

In 1928–31 an annual average of 2.6 out-of-hospital doctor visits was reported by white persons in the country, against a figure of 4.8 in 1957 for the entire population.

During the same period, the proportion of persons seeing a physician at least one a year climbed from 48 per cent to 63 per cent.

In 1929, said the Foundation,

Americans spent a total of $3 billion on health care. Such health care includes personal health services purchased by private individuals: hospital costs, drugs, appliances and professional services. Not included: spending by government, national, state or local, or money spent by companies and charity organizations.

Dropping under $2 billion in 1933 as the result of the depression, money spent on health care climbed again in 1934 and has risen ever since. By 1957, the total was $5 billion, an increase of about 6% a year.

Public Willing

The public is willing to spend more for hospital care, according to George Bugbee, President of the Health Information Foundation.

In an article published in the January 1 issue of *Hospitals*, the Journal of the American Hospital Association, Mr. Bugbee said, "No study has shown that the public thinks health insurance premiums or subscription rates are too high."

"Everyone complains about the amount spent for hospital care, but the public shows no willingness to go without hospital care," Mr. Bugbee said. "I believe the American public is willing to spend more for hospital care and looks on such expenditures as sensible."

Mr. Bugbee stated, "There is no proof of overuse of hospital care. As a practical matter, I think use is just about what the public wants."

Mr. Bugbee defended the voluntary hospital system saying, "If hospitals are going to accept arbitrary controls on income and use that supposedly cannot be controlled intelligently with our present system, they are collapsing in the face of unfair criticism and rendering nothing in better public service."

APPOINTMENTS

The Food and Drug Administration has announced the appointment of John H. Guill, Jr. as Chief of the Chicago District of the FDA which serves the eastern third of Wisconsin, including Milwaukee, Green Bay and Sheboygan.

Mr. Guill's office can be reached by addressing U. S. Department of Health, Education and Welfare, Food and Drug Administration, 433 West Van Buren, Chicago.

PRESS

Look's Look

Out from the magazine's cover stared three white figures. Gowned, capped and masked, they looked sterile, impassive—and slightly inhuman.

The headline was designed to sell: A Searing Report on Hospitals Supressed By Doctors Who Found It "Too Hot To Handle". Inside, the banner treatment continued: The Patient's Needs Come Last. And the story's opening sentence solemnly rendered the diagnosis: "A hospital is not a fit place in which to be sick."

Thus did *Look* magazine, in its February 3rd issue, launch a blast at U. S. hospitals everywhere, and incidentally hope to increase its circulation.

Look's article was based on a once-confidential report, written for the California Medical Association, that had been kicked around in the press months before. The report had revealed some sensational stories of just eight California hospitals, many of which were impossible to document. The whole matter had been reviewed in *The Modern Hospital* as early as October of last year.

No Doubts. While pointing out that his article was tied to the California report, *Look's* medical editor clearly imputed that the country's hospitals in general left no doubts in his mind that "most patients' gripes are completely justified."

As the AMA answered the attack on a national scale, Dr. W. B. Hildebrand, president of the State Medical Society, left no doubts on the quality of Wisconsin hospitals.

"The patient comes first in Wisconsin hospitals," said Dr. Hildebrand, in a statement issued to the press. "Wisconsin's 163 general hospitals are doing a magnificent job of providing high quality care . . . the magazine's charge . . . has no application to the fine hospitals of this state."

Carefully backing up his statement, Dr. Hildebrand pointed to the current maternal mortality institutes being conducted in the state and a February session of the Wisconsin Commission for the Improvement of Patient Care as examples of concern for patient needs.

"Smog." Dr. Hildebrand regretted that *Look's* limited study had resulted in an "unfortunate" undermining of public confidence in all hospitals.

"Apparently California's smog," concluded Dr. Hildebrand, "has befogged the usual vision of *Look's* editors."

Editorial comment from around the state seemed to agree with Dr. Hildebrand. Said Neenah–Menasha's *Twin City Record* summing it up: "Body blow to hospitals just big blow for sales."

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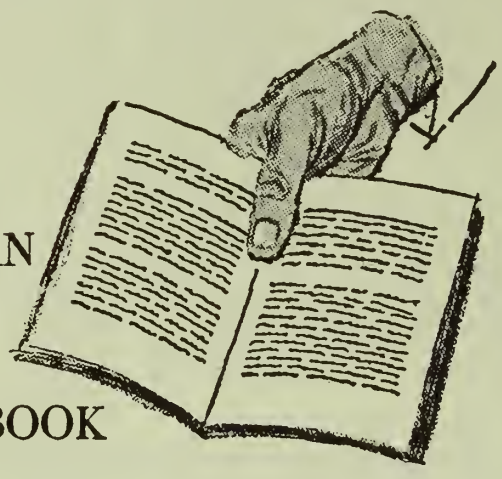


AN OPEN BOOK

When the medical profession
approves a new remedy,
it is made public
so that everybody may benefit from it.
Poliomyelitis vaccine is a good example.

Should you read or hear about a "secret
remedy" for the cure of some serious disease,
be on guard. Shun it by all means,
because its use could be disastrous.

Consult your physician.
Ask his views on "mystery remedies."
He will give you a candid evaluation.

There is nothing hush-hush about medical research
and its discoveries. Medicine is
an open book — for all the world to see.

Lignell Rexall Drug

ARTHUR MOIN

1022 Tower Ave. Dial 2-8553

Sound doctor–pharmacist relationship is being promoted in Wisconsin today by the use of advertisements (see above) such as the one that appeared in a December issue of the *Superior Telegram*.

MISCELLANY

A new million-dollar Medical Institute operated by Local 88, Amalgamated Meat Cutters opened in November in St. Louis. It will provide "complete out-patient medical care and dental exams to 3,300 union members as well as their dependents."

Group Health Cooperative of Puget Sound in Seattle has authorized construction of a three million dollar hospital to be opened in March, 1960. It will serve a prepaid consumer-controlled group practice plan covering nearly 50,000 enrolled persons with "complete medical, surgical, pediatric and maternity care."

EDUCATION

Record Year

In a special bulletin last month the American Medical Education Foundation announced that 1958 had been a record year for contributions.

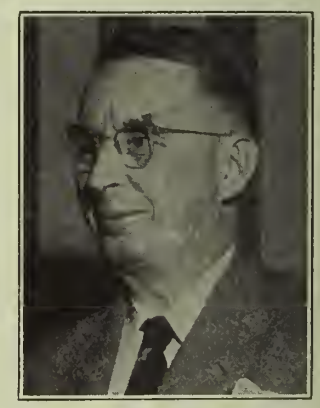
The AMA's Foundation, which raises unrestricted funds to support medical schools, had reason to be proud. In all, a total of $1,133,654 had been contributed in a 12 month period. The jump in income, said the Foundation, was 15% above 1957's total of $984,884.

The result, stated AMA president Dr. Gunnar Gunderson, was ". . . evidence of organized medicine's increasing concern over the financial plight of its schools."

Wisconsin's contribution was about midway on the list of state totals: $8,611.23. But while the Foundation's national funds had shot up 15% over last year, Wisconsin's share in dollars had slipped down $75.77 from 1957's total of $8,687.

In reporting its banner year, the Foundation said the month of December had also established a record for a thirty day period with over $540,000 being received.

The report listed the following Wisconsin physicians as contributors to the record month:



DR. GUNNAR GUNDERSEN

Wisconsin slipped down.

Appleton: Drs. Ralph V. Landis, Victor F. Marshall.

Cedarburg: Dr. Henry J. Katz.

Chippewa Falls: Dr. Charles A. Kemper.

Frederic: Dr. William A. Fischer.

Fond du Lac: Drs. Ewald H. Pawsat, Edward W. Vetter, R. L. Waffle.

Green Bay: Drs. E. G. Nadeau, George Nadeau.

Janesville: Drs. M. B. Llewellyn, John F. Pember.

Kenosha: Drs. Morris Siegel, Alfred Mayfield.

Kewaskum: Dr. R. G. Edwards.

La Crosse: Dr. Sigurd Gunderson, Jr.

Lake Mills: Dr. Marvin G. Peterson.

Madison: Drs. John A. Buesseler, Robert E. McMahon, John T. Mendenhall, J. N. Moore, Carl N. Neupert, H. K. Tenney, M. C. Winston, Larry H. Hogan.

Marshfield: Drs. John L. Burns, Jr., G. L. McCormick, Charles A. Veddar.

Mauston: Dr. J. H. Hess, Jr.

Milwaukee: Drs. Norbert G. Bauch, E. J. Behnke, S. S. Blankstein, R. W. Byrne, Donald L. Knutson, Albert G. Martin, S. A. Morton, J. C. Peterson, Eliz. D. Procter, Gorton Ritchie, E. C. Schmidt, Frank X. Schuler, H. G. Spear, Dexter H. Witte, John O. Chamberlain, Owen Royce, Sakaguchi Shimpei, Yoshira Taira.

Milton: Dr. Robert P. Lyons.

Princeton: Dr. G. G. Mueller.

Oconomowoc: Dr. Albert F. Rogers.

Rice Lake: Dr. William F. Vaudreuil.

South Milwaukee: Dr. Harold H. Oberfield.

Stevens Point: Dr. Reon H. Sanders.

Superior: Dr. Thomas J. Doyle.

Waterford: Dr. H. W. Bardenwerper.

West Bend: Drs. Albion H. Heidner, A. T. Grundahl.

Contest

An essay contest for students in 10–12 grades has been announced by the Washington–Ozaukee County Medical Society.

The contest, with $200 in cash awards, is part of the 1959 Association of American Physicians and Surgeons Freedom Programs, Inc. for high school students. The top winner in Washington or Ozaukee County, said Dr. R. G. Edwards, Kewaskum, would be eligible for $2,675 in prizes at the national level.

Prizes will be given for the best essays on either of two topics, "The advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System."

ECONOMICS

Personal Planning

People usually have larger estates than they realize. When you add up all that you are worth, together with your life insurance and other benefits, you may be surprised at the total.

Many people believe that estate planning and trust planning is only for the man of above average means. The experience of lawyers clearly indicates that many wives and families have been deprived of substantial benefits because of this mistaken belief.

It is good business for you to find out whether you need more than just a will to make careful provisions for your family and the disposition of your property in order to do the greatest good at the least possible expense.

Simple estate planning and will drafting go hand in hand. First of all, you must know what property you have. If you have never stopped to consider this problem, you should do so now. You can start by filling in the check list (see box) and totalling the figures.

Your lawyer can then help you develop a personal, practical plan for your lifetime and estate. You will thus be protecting yourself and your family.

How Much Is YOUR ESTATE Worth?

It may be larger than you think. Use this checklist to find out --

Cash	$_____
Checking Account	_____
Savings Account	_____
U. S. Bonds	_____
Building & Loan Savings	_____
Life Insurance (both personal and company or group policies)	_____
Stocks and Bonds	_____
Real Estate	_____
Personal Property (include household items, furniture, boat, valuable collections, etc.)	_____
Automobiles	_____
Other	_____
TOTAL	$_____
Add to consideration of this total:	
Monthly benefit due under Social Security	_____
Benefit due under pension plan where you work	_____
TOTAL	$_____

After determining your total assets, it may be worth your while to seek the advice of your attorney on such points as your will, jointly held property and simple estate planning problems.

HAVE AN ANNUAL LEGAL CHECK-UP

QUACKERY

Fit for a Queenbee

The hucksters were at it again. Latest of the nostrums being promoted for rejuvenation was Royal Jelly. The jelly is actually a special food prepared by worker bees for those they select to become queens. The queenbee lives far longer than the workers, grows many times larger and lays millions of fertile eggs.

Recently hucksters have been as busy as bees putting minute amounts of royal jelly into capsules or cosmetics, and offering these products to restore youth, beauty, vitality.

Said Arthur S. Fleming, Secretary of Health, Education and Welfare: "For bees, royal jelly is indeed a miracle food, but it has no practical value for humans as a food, drug or cosmetic. The claims made for it are groundless."

The National Better Business Bureau has distributed a bulletin on the subject to all advertising media.

* * *

New Film. Food quackery has been pinpointed in a new 27-minute film produced by the AMA. Prepared for telecasting over local TV stations under the sponsorship of county medical societies, it depicts how quacks gull the public into spending millions of dollars on unnecessary or over-priced food supplements.

Recently the film was shown in Wisconsin by the Redemptorist Fathers, Oconomowoc, Marinette County Teachers College, Marinette, and the Spence McCord Drug Club, La Crosse.

The film may be booked without cost directly from the AMA or from the State Medical Society.

Winners in the state-wide bowling tournament (see story) were (l. to r.) Mrs. and Dr. A. C. Theiler, Mrs. B. Marsho, Drs. J. W. Boren, Jr., J. B. Baldi, W. J. Madden and S. J. Sweet.

SPORTS

Winners

On the first Saturday in February, 92 bowlers from around the state gathered in Madison to compete in the third annual Wisconsin Doctor's Bowling Tournament. Winners in six opening bowling events:

Men's Singles, Class A: 1st Place—Dr. Samuel J. Sweet, Milwaukee; 627 total; 2nd Place—Dr. John B. Baldi, Milwaukee, 623; High Single Game Class A—Dr. Baldi, 247.

Men's Singles, Class B, 1st Place—Dr. W. J. Madden, Racine, 568 total; 2nd Place—Dr. E. F. Winter, Oshkosh, 543; High Single Game, Class B.—Dr. W. H. Williamson, Racine, 226.

Men's Doubles: Drs. J. B. Baldi, 623 and J. Boren, Jr., 524, Marinette, 1147 total; 2nd Place—Drs. K. G. Pinegar, Marinette, 570 and W. J. Madden, 568, total 1138.

Women's Singles: Mrs. Bernard Marsho, Sheboygan, 549 total; 2nd Place—Mrs. Alvin C. Theiler, Kiel, 524; High Single Game—Mrs. B. Marsho, 201.

Mixed Doubles: Dr. and Mrs. A. C. Theiler, 660 and 551; 1211 total. 2nd Place—Dr. and Mrs. R. Dodge, Janesville, 1053 total.

Team Event: Drs. C. A. Vedder, A. M. Kinkella, R. L. Smith, F. J. Gouze, T. J. Rice, all of Marshfield, 2573 total; 2nd Place—Drs. S. J. Sweet, N. A. Gendlin, G. E. Collentine, Jr., J. D. Conway, J. B. Baldi, all of Milwaukee, 2569 total.

A dinner, during which awards were presented, was held at Madison's Edgewater Hotel. Master of Ceremonies was Dr. C. M. Carney one of the founders of the tournament. Dr. and Mrs. L. E. Holmgren, Madison, represented the Dane County Medical Society, the host organization.

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THE WISCONSIN MEDICAL JOURNAL

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Responsibility of Authorship*

By KENNETH E. LEMMER, M. D., F. A. C. S.**

Madison, Wisconsin

SOME of the practices which may influence the accurate reporting and clear interpretation of scientific articles can be listed as follows:

1. The competition for priority of publication.
2. The requirement for numerous articles published.
3. The failure to limit the article to the stated title.
4. The improper evaluation of statistics, especially in a limited series of cases.
5. The publication of a single case report with conclusions.
6. The "crusader" who has a pet project or an axe to grind.
7. The paucity of retractions published when prior recommendations prove to be of little or no value.
8. The evolution of the science feature writer.

1. *The competition for priority of publication.* We, as Americans are obsessed by the illusion that to be first in any given area or circumstance is of paramount importance. The true scholar shrugs it off and proceeds to work out his problem in detail before offering it for publication. This may require a long period of time in the laboratory or clinic with repeated appraisal of the material before it can be written up for publication. This is not so with most of us; we must hurry to get it in print so as to obtain a priority status. This is particularly true in the new drug field where it has been estimated that at least one new drug a day is developed by the pharmaceutical industry. There is no time for the tedius checking and rechecking so essential to properly evaluate a new drug or procedure. This frequently results in a poorly thought out, and an incomplete, or inaccurate presentation. The title may be listed as a preliminary report, but frequently it is not; and often it represents the only offering of that author on the subject. Often the failures are not reported and the glowing preliminary reports stand in the literature as the final word even though the practice or use of the drug may have been discontinued by the author. Perhaps it would be better if each paper were placed in cold storage for 6 to 12 months. At the end of this time the paper should be reviewed and if still pertinent, it should be published.

2. *The requirement for numerous articles published.* Some institutions require a minimum number of articles to be published yearly by each staff member. This results in a large output of publications which flood the offices of the medical editor and cause a bogging down and delay in publication of all types of presentations. Promotions or new

*Presented at the one hundred seventeenth meeting of the State Medical Society May 8, 1958, Milwaukee.

**From the Department of Surgery, University Hospitals, Madison, Wisconsin.

appointments frequently are granted to the prolific writer, often with too little regard as to the quality of the material presented. It should be pointed out that many excellent clinicians and teachers may not be prodigious writers and prefer to write only those articles which have something of value to present. It should be obvious that the immense waste of both ink and paper in many medical journals could be obviated by a sane return to the publication of medical articles only when and if indicated.

3. *The failure to limit the article to the stated title.* This is a rather common error and it is one which may not only be misleading but may be actually dishonest. It may arise from the circumstance that the title is selected before the paper is written rather than the reverse, which should be the case. The title should be short and to the point. It should accurately describe the material within the paper and may be supplemented with a subheading if necessary. It should not promise something which the paper itself cannot deliver. Clarity is important and the use of obscure words or combinations of words may occasionally catch the eye of some individual, but by and large, they will cause the paper to be passed up by the average reader.

4. *The improper evaluation of statistics especially in a limited series of cases.* This is a real problem and many medical schools now offer courses in biometry and medical statistics. This allows the student to determine whether the results observed occur as the result of chance or are really significant statistical trends or variations. Even expert statisticians, however, fail to agree at times as is evidenced by the recently published articles regarding cigarette smoking and lung cancer in the March–April Cancer Bulletin.[1] Dr. Joseph Berkson, the distinguished biometrician at the Mayo Clinic believes that it would have been theoretically possible for one of the statistical studies to have resulted from sampling bias, whereas four other distinguished statisticians have pointed out the weakness of his argument and disagree with him.

$$\frac{(a-b)^2}{a+b} = 4$$

$$\frac{(26-15)^2}{41} = \frac{121}{41} = 2.9$$

$$\frac{(27-14)^2}{41} = \frac{169}{41} = 4.1$$

Allen Gregg[2] offers a good working rule to apply for drawing sound inferences from small numbers of cases. The following is an exerpt from his article, "On the reading of the medical literature." "Let the total number of cases be called 'a' and 'b' where 'a' stands for the number of positives and 'b' the number of negatives. You are reasonably safe if $\frac{(a-b)^2}{a+b} = 4$ or more. Thus in a series of 41 cases, if 26 are positive and 15 are negative, the result works out to only 2.9; and 26 out of 41 is not significant because it does not significantly exceed mere chance. But if there had been 27 positive and 14 negative, then $\frac{(a-b)^2}{(a+b)}$ would have equaled 4, which begins to be significant." This formula was pointed out to him by a mathematician, R. A. Fisher, and is readily applied to any medical report involving a small series of cases.

5. *The publication of a single case with conclusions.* The careful reporting of an obscure case or the unusual response of a common case may result in a very enlightening paper. This is a factual report and is a matter of record in the literature. Any attempt however, to draw conclusions as to drug therapy, general management or prognosis is obviously of little value and is apt to be misleading.

6. *The "crusader" who has a pet project or an axe to grind.* This may be exemplified by the specialist who has gained fame, either through his own work or by inheritance. He seizes upon a certain facet or technique of medical practice and expounds upon the thesis at each and every meeting which he can gain admission to the program. Often the thesis is not new but is a revision or revival of an old procedure and frequently it represents a radical departure from present-day accepted methods of therapy. This in itself is not bad, unless the method influences other practitioners to treat their patients with inferior methods and then harm has been done. Crusaders are necessary in the practice of medicine, and we should encourage those who have honest goals and sound logic to their thinking; but we should not confuse the wanderings of senility with those of the agile mind looking for new frontiers in scientific medicine.

7. *The paucity of retractions published when prior recommendations prove to be of little or no value.* No one who has published a large number of papers is ever satisfied with all of them and there is usually one or more which the author has later wished that he had never written. Most of these papers were honestly thought out and carefully presented; but some later development revealed a grievous flaw, either in the thinking or in the process, which led to its abandonment. The literature, however, still records the material as presented. On a rare occasion the author may present a follow-up paper pointing out the deficiencies in his article, or on occasion this may be accomplished by some other author's publication. Many physicians, however, may not come in contact with these articles and may continue the method of treatment of the original paper long after its author and others have decided that the concept has no merit. This is particularly true of the physicians away from the larger medical centers who rely on the journals to keep up-to-date. In an editorial in the MASSACHUSETTS PHYSICIAN for May 1957,[3] titled, "Responsibility of Authorship," it was stated that, "Publication of favorable results carries the moral obligation of immediate rectification or retraction if the recommendations later proved to be of little or no value." I recently saw such a retraction published in the NEW ENGLAND MEDICAL JOURNAL, which is one of the few journals which follow this plan. It is my suggestion that a section of each of today's numerous medical journals be reserved for just such retractions.

8. *The science feature writer.* Medical papers are a frequent source of newspaper and magazine articles today. It is a growing trend to have science reporters and their photographers in attendance at medical meetings. This accounts for an early dissemination of medical information to both the medical and nonmedical population. TIME magazine, as an example, has had a section devoted to medicine for many years. This is current and recent and usually reveals the newer advances in medicine long before the scientific journals, which have a 6-to-12-month backlog of papers. The READER'S DIGEST, COLLIERS magazine, the SATURDAY EVENING POST also run medical features in nearly every issue. In addition, this material is often presented in the movies, television, radio, novels, and even in comic strips. Much of this is good because it educates the public to the problems of medicine. Frequently, however, experimental papers are widely reported, controversial problems are solved by leaving out part of the issues, and emphasis is frequently placed on improvements or results which are not significant. Accuracy in reporting may give way to the spectacular. This is particularly true when dealing with so-called cancer cures. The moment a new treatment is reported the

patients bombard the clinic or hospital with pleas for treatment. Up to the present time, no treatment for cancer has lived up to its initial reports and promises. There is no doubt that science feature writers are here to stay and therefore it is up to us, not only to see that the material which they obtain concerning our presentations is accurate, but also that in their write-ups no unjustified claims or results are reported.

1300 University Avenue.

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PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Box 1109, Madison 1, Wisconsin.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11 with one inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wis. Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

The Surgical Approach to Ulcerative Colitis*

By MARK M. RAVITCH, M. D.**

Baltimore, Maryland

SINCE 1875[1] when ulcerative colitis was first sorted out and separated from the various other diseases characterized by chronic diarrhea, there has been a steady progression in the aggressiveness of surgical thought directed to its treatment.

Mayo Robson's[2] sigmoid colostomy was performed to permit more efficient irrigation of the diseased bowel with astringent medication than could be achieved by enemas alone. Cecostomy, appendicostomy and ileostomy were natural extensions of this concept, and perhaps its most radical application came in Hochenegg's isolation of the diseased bowel, opened at the two ends for irrigation, while continuity was restored around it.

By 1914 John Young Brown[3] of St. Louis, and others, were pointing out that a terminal, rather than a tangential ileostomy, had the advantage of putting the colon at rest; and that this is of greater importance than provision of an opening for access to the diseased bowel for irrigation. There followed the increasing awareness that ileostomy had to be performed before patients had reached Stone,[4] Fred Rankin, Frank Lahey and others the stage of impending dissolution. Harvey repeatedly urged earlier resort to operation.

The result was a presently lowered mortality from ileostomy and a greater salvage from the disease. It was evident that most patients with mild ulcerative colitis, could be treated without operation and that fulminating cases were likely to die in spite of operation. The course which might be followed after apparently successful ileostomy came to be recognized as falling into several patterns.

1. In the most brilliant cases—unhappily an extremely small group—the patient improved rapidly, was restored to full health, and the bowel, by all available indices, recovered as well. Endoscopy, roentgen examination, microscopic study of saline enema returns, showed no evidence of disease. In these rare instances, if the ileostomy was now closed, the disease recurred in some patients, at times with great violence; but in an occasional instance, recovery appeared permanent. Cattell[5] reports 50% failures in such attempts.
2. In the least fortunate cases, ileostomy failed to affect the disease, either in its systemic or local manifestations; and the patient either died, or much later began a slow improvement, not apparently attributable to the ileostomy.
3. More commonly the general condition of the patients improved vastly at the same time that the activity of the disease in the colon continued to be manifested by discharge of blood and pus and progression of the disease process was seen endoscopically and radiologically. There were, of course, wide variations, from instances of fairly mild, though persistent disease, to others of symptomatically troublesome disease, with recurrence of systemic response in the form of fever, debility, weight loss, anemia, arthritis.

In the late 1930's it became apparent that many of the patients in the third group, while their lives might have been saved by ileostomy, could not hope for restoration to full vigor unless the colon were to be removed. At this period it became common practice to perform ileostomy, and then in three or four subsequent stages to perform total colectomy, and in some patients, in addition, an abdominoperineal resection. Resection had at times been practiced before, notably by Arbuthnot Lane, but had not found widespread acceptance.

The awareness that colectomy would ultimately be necessary in most patients requir-

*Presented at the one hundred seventeenth meeting of the State Medical Society, May 8, 1958, Milwaukee, Wisconsin.

**From the Departments of Surgery of The Johns Hopkins University and Hospital and The Baltimore City Hospitals, Baltimore, Md.

ing ileostomy for ulcerative colitis, and that the resection of the diseased bowel at the time of ileostomy would relieve the patient of his disease and allow for more sure and rapid recovery, led Crile and Thomas,[6] Cave,[7] Miller, Ripstein and Tabah[8] and Miller, Gardner and Ripstein,[9] and others,[10] to suggest subtotal resection of the colon at the time of ileostomy and to carry this to its logical conclusion, and advise emergency resection of the colon in the profoundly ill patients. Actually in March, 1949, Miller and associates[8] advocated ileostomy and right colectomy and by June, 1949, were advocating resection to the lower sigmoid.

The maturing of surgical thought in respect to the more severe cases of ulcerative colitis, the inevitability of total colectomy, the lessened risk of one operation, one incision, one anesthesia, the advantage of immediate ablation of the diseased bowel, led us, in 1947,[11] to perform the entire colectomy and abdominoperineal resection in one stage. Goligher, in 1953[12] and 1954,[13] and Hughes and King in 1955,[14] reported 14 and 6 one stage pan colectomies, respectively. Nickel in 1955[15] reported 8 additional proctocolectomies. Early, it was our attitude that the colectomy should be carried around to the sigmoid colon and the situation appraised. If the operation had been clean without rupture of the friable bowel, had been free from significant blood loss, and if the condition of the patient showed no sign of deteriorating, the operation was continued and the abdominoperineal resection performed. If these criteria were not met, the operation was interrupted and the abdominoperineal resection performed at another sitting.

A number of observations have led us to modify this attitude and to disregard these criteria. There have been reported, and we have observed such a case, instances of fatal hemorrhage from the retained rectum within a few days of abdominal colectomy. The operation for exsanguinating hemorrhage from the retained rectum is a formidable procedure, but at the time of the original colectomy an abdominoperineal resection adds relatively little to the operative procedure if the patient has been prepared and the combined lithotomy-Trendelenberg position, or Fallis' technique, for abdominal removal of the rectum and anus is employed. (Goligher reports a similar technique). In two instances in patients operated upon for fulminating disease and considered "too sick" for the completion of the procedure, necrosis of the foul infected distal bowel, retraction, wound infection, and continued sepsis, presented a more profound risk to the patient's survival than would have the completion of the procedure in one stage, which would have removed all the diseased tissue and left the patient with a clean abdomen and pelvis. And finally, the abdominoperineal resection at a separate stage, simple though it may be at times, is more taxing to surgeon and patient than completion of the one stage procedure.

For these reasons then, in performing a total colectomy with abdominoperineal resection, it is now our policy to complete the entire procedure at the time of the ileostomy, even and particularly in the most profoundly ill patients. Those moderately debilitated patients, with intractably diseased colons, will usually tolerate the definitive one stage procedure. Those patients with fulminating disease—septic suppurative, perforative, or hemorrhagic—stand a better chance of surviving if all of the diseased bowel is removed. The operation itself, of whatever magnitude, can be borne by the patients, provided that when they leave the operating room they no longer have within them the diseased bowel.

There are those like Aylett[16] and Corbett[17] who, willing to accept considerable risks to avoid a permanent abdominal ileostomy, anastomose the ileum to the rectum, even in the face of frank rectal disease. Success may apparently be achieved in this way at times, but exacerbation of the disease in the distal bowel is common after a period of time. The follow-up of Aylett's cases is still relatively brief. Still if with a rectal anastomosis, one can achieve a delay of several years in the establishment of an abdominal ileostomy, it may be thought worthwhile. We have only rarely found cases which seemed suitable for this operation and have performed it only when the rectum itself seemed essentially normal.

Our indications for total colectomy and abdominoperineal resection—pan colectomy—in ulcerative colitis, are the following:

1. *Intractable colonic disease with debility, anemia, arthritis or incapacitating diarrhea.* The mere fact that a patient has "escaped operation" does not constitute a therapeutic triumph if he is an emaciated semi-invalid, frequently con-

fined to bed or hospital, constantly requiring medical attention and is rarely at anything like a proper level of vigor and activity. The startling change in such patients after colectomy often leads them to ask why operation had not been recommended earlier.

2. *Life threatening, fulminating attacks with high fever, tachycardia, edema, hypoproteinemia, free perforation or threatened perforation.* We are unable to understand the counsel of those who advise "conservative" treatment of perforations in the hope that they will seal off. Operation should be undertaken at once for suspected perforation. In fulminating attacks of essentially suppurative disease, if three or four days of nonoperative therapy, including steroid therapy, (which carries with it, unfortunately, an increased likelihood of perforation) fails to produce striking improvement, operation should be undertaken.
3. *Massive hemorrhage.*
4. *Long, continued disease with severe radiologic deformity, even in patients symptomatically comfortable.* Resection here may be advised to prevent the risk of the development of cancer, a risk perhaps 31 to 60 times greater than in other people of the same age in the general population. Estimates of the incidence of carcinoma of the colon in patients with ulcerative colitis run from 8% to 36% and increase with the duration of the disease.[18-20] We have now operated upon four patients with carcinoma developing in long standing chronic ulcerative colitis. All four patients are dead. Three of them had been "medically regulated" and one of them had had an ileostomy for 17 years, with the colon retained.

The operation of anal ileostomy which we proposed originally in 1947[21-23] as a means of allowing total colectomy with preservation of sphincter function has proved to be entirely satisfactory in multiple polyposis. In ulcerative colitis, on the other hand—although we have one brilliant and another satisfactory result after a very long follow-up—the failures have been so much more numerous that we are inclined to think that the diseased rectum of patients with ulcerative colitis is unsuitable for this operation and the personality of these patients is certainly too often inadequate to withstand the initial postoperative discomforts. Furthermore, today ileostomies are much better managed than formerly.

Technique of One Stage Ileostomy and Pan Colectomy

Preoperative preparation begins with administration of as much blood as is required to correct any anemia, and intravenous human albumin 50 gm. a day, to correct hypoproteinemia. In those cases in which time affords, antibiotic preparation consists in oral administration of neomycin 1 gm., and sulfathalidine 4 gm., every four hours for 48 hours before operation. A single lumen, indwelling, long intestinal tube is passed to the ileocecal valve. This tube serves several functions:

1. At operation the small bowel is reefed upon the tube and readily held out of the way with a single laparotomy pad.
2. During the postoperative procedure, there can be no question of mechanical intestinal obstruction of the small bowel through which a tube has been threaded, and,
3. If adhesions develop, they develop in bowel which is naturally disposed and one can hope that there will be a minimal likelihood of subsequent intestinal obstruction. Furthermore, the lack of necessity for handling the bowel during operation tends to minimize the number of adhesions which form. Penicillin, 600,000 units, and streptomycin 0.5 gm. are given before operation and twice daily thereafter for five days.

Operation is performed with the patient in the combined lithotomy-Trendelenberg[24] position, of which the essentials are:

1. Elevation on a sacral rest to tilt the pelvis forward.
2. Wide abduction of the hips, and . . .
3. Minimal flexion of the hips. Abdomen and perineum are simultaneously draped out, with a catheter in the bladder strapped to the inner aspect of the thigh.

Incision is made from the pubis to above the umbilicus which is excised. The ileostomy will be placed in the midline incision, and retention of the umbilicus would complicate

fitting of the ileostomy appliance, and toilet of the abdominal wall.

The weight of the indwelling tube and of the intestine reefed on it makes the handling of the small bowel almost effortless, even with light anesthesia. The small intestine being displaced to the left, the right colic peritoneal attachments are divided and the hepatic flexure freed. One or two vessels in the peritoneal attachments of the hepatic flexure require ligation. The small bowel being now displaced towards the pelvis, the gastro colic omentum is clamped, divided, and transfixed. This is considerably quicker and less bloody than dealing with an inflamed colon in dissecting the omentum off the colon. The small bowel is now displaced to the right, and the left colic peritoneal reflection divided. With traction on the transverse and descending colons, both held in the left hand, the splenic flexure is brought into view and its tautened suspensory ligament divided. The entire colon, blood supply undisturbed, is now delivered on the abdominal wall, and the division of the mesentery accomplished actually outside the abdominal cavity and with minimal effort. A rubber shod clamp across the terminal ileum prevents the proximal vasculature from pouring blood into the segment being removed. Any edematous or inflamed ileum is included in the resection, but an effort is made to avoid sacrificing any ileum which appears healthy; in the conviction that the more functioning terminal ileum left, the better the patient's status.

The mesenteric vessels are clamped, divided, and transfixed conveniently close to their origins. Only now is the Trendelenberg position asked for. The superior hemorrhoidal vessels are secured and a pelvic peritoneal incision outlined closely about the rectum. There is no need, in operating for benign disease, to sweep away from the bowel. A maximal amount of peritoneum is preserved and dissection is carried close to the rectum to avoid the ureters. Carrying the dissection close to the bowel in these patients avoids interference with sexual function in males, as opposed to the situation after abdominoperineal resection for cancer. The dissection of the rectum within the pelvis proceeds in the usual fashion. We have not tried Fallis'[25] or Goligher's method of abdominal removal of the rectum and anus, but, having freed the rectum to the levators, descend to the perineum. The anus, purse-stringed with heavy silk during the draping, is circled with the electro cautery, the levators divided, and the specimen liberated. The perineal wound is closed around a drain, the pelvic peritoneal floor is repaired, and the ileostomy brought out through the upper third of the midline incision. If the ileostomy is brought out through the midline, there can be no problem about strangulation of bowel between the ileostomy and the lateral abdominal wall, and furthermore, patients find it easier to attend to a midline ileostomy than to one which requires them to twist their trunks. Furthermore, the slight fullness of the bag under the clothes is symmetrical in the midline and the anterior superior spine does not interfere with the application of the bag.

No time is wasted on the unnecessary "peritonealization" of the gutters, which is, in any case, almost an impossibility. The wound is closed and the ileostomy everted, either full thickness or occasionally after excision of a muscular cuff, and sutured to the skin edge.[26,27] The wound is sealed off with collodion or other material, and a polyethylene ileostomy bag applied at once. As soon as there is abundant ileal drainage, suction on the indwelling long tube is discontinued and oral feedings are begun. If these go well, in 24 to 48 hours the long tube is withdrawn.

We have now performed at the Johns Hopkins Hospital and at the Mount Sinai Hospital in New York, over 30 one stage pan colectomies; ten of these have been for polypoid adenomatosis, and in nine of these the procedure of anal ileostomy was added.[28] The remainder were for ulcerative colitis and in four of these anal ileostomy was added. In the entire series there has been one death—a woman, profoundly ill with ulcerative colitis, who had had a Noble plication procedure of the ileum added to her pan colectomy—the only one in this series. She tolerated the operation very well but the ileostomy failed to discharge and exploration demonstrated obstruction to the plicated bowel. As the bowel was being released, the patient, whose condition had been good, developed a so-called cardiac arrest. From this she was resuscitated, but ultimately died after some days of decerebrate life.

Summary

Pan colectomy (one stage total colectomy and abdominoperineal resection of the rec-

tum) is the preferred procedure for patients requiring operation for ulcerative colitis. The less profoundly ill patients will tolerate the one stage procedure without difficulty and will be spared the risk of additional anesthesia, incision, operative procedure. The more profoundly ill, will derive sufficient benefit from the ablation of the diseased bowel to compensate for the moderate increase in magnitude of the operative procedure and will be spared the dangers of sepsis or hemorrhage attendant upon retention of the diseased rectum in ulcerative colitis. Such patients can tolerate the operation more readily than they can the retention of the diseased bowel.

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American Board of Obstetrics and Gynecology Examinations

The next scheduled examinations (Part II), oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 8 through 19, 1959. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I Examinations will be notified of their eligibility for the Part II Examinations as soon as possible.

The deadline date for the receipt of new and reopened applications for the 1960 examinations is August 1, 1959. Candidates may submit their applications at any time before that date.—Robert L. Faulkner, M.D., Secretary–Treasurer, 2105 Adelbert Road, Cleveland 6, Ohio.

Encouraging Results for Therapeutic Apparatus

Encouraging results in use of a "problem-solving" apparatus as an aid to treatment of mentally ill patients were reported by the Battle Creek, Michigan, Veterans Administration hospital recently.

By offering simple problems in mechanics, the device challenges withdrawn patients to enter into activities and communicate with each other, VA said.

Research with the apparatus was conducted by Dr. Stewart G. Armitage, chief of the hospital's psychology service, and Dr. Gerald F. King, assistant professor of psychology at Michigan State University.

Doctor Armitage and Doctor King worked with severely ill mental patients who had failed to respond to standard methods of treatment, including tranquilizing drugs. These veterans were extremely withdrawn, detached from their environment, and uncommunicative. Some were mute.

The device, placed in an eight-foot-wide panel across the alcove of a large room, gives the appearance of being an extension of the wall. Projecting from the panel are handles, and beneath these are slots opening into trays. Centered above the handles is a screen for projecting slides.

Patients at first are given simple problems of moving the handles in patterns to turn on colored lights in the panel, project slides, or pass objects through the slots.

The tasks gradually become more complex, and patients help each other in operating the apparatus. Soon they are able to work in pairs and cooperate with each other to achieve results.

Each of a group of 12 patients received three 20 to 30 minute sessions with the apparatus weekly for 15 weeks at the Battle Creek VA hospital. They also participated in the hospital's usual therapeutic activities, such as occupational and corrective therapy.

Doctor Armitage and Doctor King said definite improvement was noted in the mentally ill veterans. Two who had not spoken for four years began to talk. Soon after beginning to work with the apparatus, one of the long-term mute patients greeted the therapist with, "Good morning." Others showed an interest in the apparatus and began to ask questions about it.

VA said that while use of this device represents a minor part of the over-all treatment, the apparatus has proved of definite help in getting patients to participate more fully in therapeutic activities.

Wisconsin Neurological Foundation Now Accredited

The Wisconsin Neurological Foundation hospital, 1954 East Washington Avenue, Madison, has been accredited by the Joint Commission on Accreditation of Hospitals, according to a letter received recently by John B. Mathews, Foundation Administrator.

The accreditation, which came less than a year after the Foundation purchased the Washington Avenue hospital building from the city last January, followed an inspection and evaluation of the Foundation facilities last November by a field representative of the Commission.

"The Commission wishes to commend you for maintaining standards deserving of accreditation and for your constant effort to improve the quality of patient care," Dr. Kenneth B. Babcock, Chicago, director of the Commission, stated in his accreditation notice.

Member organizations of the Joint Commission on Accreditation of Hospitals are the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and the Canadian Medical Association.

The Foundation, which was established in 1950 as a private, nonprofit, charitable organization, provides treatment, rehabilitation and research in connection with the complete range of neurological disorders.

Mathews reported that the bulk of the Joint Commission's recommendations for further improvement of the Foundation facilities is being met by the $500,000 expansion and modernization program currently underway at the hospital. Present plans call for completion of this program by May, 1959.

Scarlet Fever Cases Increasing in State

Scarlet fever, once thought to be a disappearing disease, is staging a mild comeback this winter.

Reports reaching the State Board of Health indicate increasing prevalence of this disease—no epidemic to be sure, but considerably more cases than at any time during the last two or three years. —Carl N. Neupert, M.D., Wisconsin State Health Officer.

Current Considerations of Acute Hepatic Diseases

By M. C. F. LINDERT, M. D., F. A. C. P.*

Milwaukee, Wisconsin

THE APHORISM that "Appearances to the mind are that things are either . . . what they appear to be . . . or they are NOT and yet *appear* to be" applies when the clinician is confronted with an acute hepatic disease. Most physicians are well indoctrinated in the clinical and laboratory features of viral hepatitis, both the infectious (IH or Virus A) and the homolgous serum or needle-syringe transmitted (HSH or Virus B) types. However, to consider every patient who presents one or several of the characteristic features of viral hepatitis as being due to virus may prove to be a serious error. This is particularly disturbing when patients are diagnosed and managed as having active hepatitis with merely an isolated abnormal liver function test, especially an abnormality of a flocculation or turbidity determination. For a brief period in recent years there were an ever-increasing number of patients who were labeled as having hepatitis without jaundice; a hazardous diagnosis!! It is not the purpose of this presentation to devote much time to the discussion of the various aspects of viral hepatitis but to alert the physician to other acute hepatic diseases.

Etiological Considerations

A number of situations must be given recognition in the differential diagnosis of acute hepatic disease. First and foremost on this list is that of *acute toxic necrosis*. This fact is readily understandable since the liver is the major detoxifying organ. With the ever-increasing use of drug therapy and chemotherapy one must be ever cognizant of possible toxic side effect upon the liver. Substances which are commonly encountered include exposure to heavy metals, toxic fumes, drugs such as the sulfonamides and others. Toxicity to the liver may not only be manifested as a hepatocellular necrosis but also as an *acute cholangiolar reaction*. Such is the mechanism observed in thorazine jaundice, methyl testosterone and arsenical cholangiolitis. Other toxins such as bacterial, tissue-breakdown products, intestinal toxins, and transfusions have all been observed to produce hepatic injury. These are not uncommonly a factor in postoperative states and in acute hemolytic episodes. When jaundice appears it is 24 to 72 hours after a surgical procedure. Medical systemic illnesses may likewise be complicated by a *toxic hepatitis*.

Bacterial hepatitis has not had as much attention in recent years, primarily because of the use of sulfonamides and antibiotics in the treatment of bacterial infections. Hepatic necrosis may at times be seen secondary to an overwhelming systemic infection such as pneumonia, bacterial endocarditis, meningitis, etc. Other bacterial infections such as brucellosis and tuberculosis have been given more serious consideration. Spirochaetal infection, particularly that of syphilis and leptospirosis (Weil's disease) is a rare occurrence but has been encountered in this community and state. Parasitic infestations such as amebiasis, fungus infections, *e.g.*, histoplasmosis, are infrequent offenders. The latter may produce a granulomatous hepatic involvement which is difficult to differentiate from other granuloma producers such as tuberculosis, brucellosis, and Boeck's sarcoid.

Malignancy, secondary or primary, and especially the latter when occurring independent of chronic liver disease, may be confused with acute viral hepatitis. Such confusion would yield a misleading prognosis and result in considerable embarrassment for the attending physician. *Anoxia* and or tissue breakdown toxicity, as mentioned previously, may produce hepatic dysfunction. This factor should receive prominent consideration in patients who have been exposed to

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prolonged surgical procedures or who have been involved in shock induced incidents secondary to surgery, trauma or prolonged anesthesia.

Diagnostic Considerations

Invariably the liver is implicated when jaundice is a manifestation. Nevertheless, there are still instances when the liver is overlooked in spite of the presence of jaundice, and it is erroneously assumed that an extra hepatic obstructive lesion is causative. This type of occurrence is becoming more and more infrequent and perhaps would not be of serious import had not toxic hepatitis of obstructive nature made its appearance or become recognizable. Such is also the case in the acute cholangiolitic form of hepatitis. In both of the aforementioned situations the intrahepatic lesion produces a clinical and laboratory picture which resembles extra hepatic obstructive jaundice. If jaundice has NOT appeared as part of the acute hepatic disease, the liver may not be considered very seriously as the primary site of disease. Here again a word of caution must be mentioned; namely, that all too often patients are labeled as having non-icteric hepatitis, based primarily on a clinical history compatible with hepatitis plus an isolated abnormal liver function test. Many of these cases eventually are proven to have no liver disease at all. I have in mind a series of cases which were recorded as having non-icteric hepatitis, most of whom were women and several of whom eventually delivered healthy youngsters. Obviously these patients were in the first trimester of pregnancy and experiencing the usual symptoms with that phase of pregnancy, and accordingly were erroneously diagnosed as having hepatitis.

There are *diagnostic clues* which should alert the physician to the fact that he is not dealing with a viral type of hepatic disease. These include features with reference to history, physical, and laboratory examinations. Historically, one may obtain a history of exposure to some form of toxin or drug, prolonged history of weakness and easy fatigability, prolonged history of high or low grade fever. The finding of a high fever over more than a week's duration is generally not compatible with acute viral hepatitis. Likewise, a marked leukocytosis is not generally found in a viral infection. A moderate to marked splenomegaly should suggest the possible nonexistence of viral disease and leads one to more serious consideration of a lymphomatous type of disease. Lymphadenopathy, although not an inconsistent finding with viral disease, should alert the physician to consideration of some other form of acute hepatic disease. Although many patients with viral hepatitis have profound anorexia and are apt to lose a certain amount of weight, they rarely progressively lose weight to the point of appearing like a patient with tumor cachexia. Laboratory aids in acute hepatic disease are generally well known but new tests do appear from time to time. Most notably during the past few years have been the observations of enzyme studies, particularly serum glutamic oxalacetic acid transaminase, serum pyruvic acid transaminase, and cholinesterase studies. Serum glutamic oxalacetic acid transaminase is not specific for hepatocellular necrosis, especially if there is any evidence of cardiac involvement.

Some investigators feel that the glutamic pyruvic transaminase test may be more specific for hepatic necrosis. The transaminase determinations may be a more specific diagnostic and prognostic guide than any previous liver function studies. Recently a report on amebic hepatitis suggested that the cholinesterase determination was the most reliable sign of activity of this type of disease involvement. Flocculation and turbidity determinations, along with electrophoretic pattern studies, continue to be reasonably reliable aids in the confirmation of the diagnosis of acute hepatic disease. Unfortunately, the reliability is more or less limited to a diffuse hepatic disease process and may not be helpful in focal hepatic disease, particularly that which is encountered secondary to granulomatous lesions and tumor disease. In the absence of jaundice the brom-sulphothalein dye excretion test is still extremely reliable in the detection of active liver disease. When one is faced with a rather atypical picture and one which cannot be conclusively diagnosed by other laboratory methods, liver biopsy should be given serious consideration. This can be accomplished either by needle punch method or by direct surgical approach. I would like at this point to present several case illustrations of acute hepatic diseases, all patients of whom have been considered as having had acute viral disease and were treated as such over a period of several months to a year or longer.

Case 1: L. C., female, age 27 years, admitted April 19, 1952, alcoholic—one fifth Scotch per day; expired May 12, 1952. Jaundice, weight loss, easy fatigue, abdominal pain, fever 104 F., anemia, leucocytosis, confusion, hepatomegaly. *Laboratory:* rapid sedimentation rate, elevated zinc and thymol turbidity, increased urinary urobilinogen excretion. *Clinical Diagnosis:* acute hepatocellular necrosis. *Autopsy Diagnosis:* Hodgkin's Disease.

Case 2: R. N., female, age 50 years, admitted November 11, 1957. Increased tiredness and easy fatigue since May 1957; nausea, anorexia and vomiting since August 1957; 30 lb. weight loss; belching and bloating six months; hepatomegaly; no jaundice. *Laboratory:* Cephalin flocculation 3 plus; increased zinc turbidity; abnormal BSP—24%; reversal A/G ratio. Expired March 4, 1958. *Clinical Diagnosis:* Doctor A., psychoneurosis; Doctor B., subacute or chronic hepatitis. *Liver biopsy,* December 1957, carcinoma of liver. *Autopsy Diagnosis,* primary carcinoma of liver.

Case 3: H. T., age 48 years, male, admitted March 4, 1957, with fever, chills, general malaise, 3 weeks' duration. *Physical examination:* hepatomegaly, splenomegaly, lymphadenopathy. *Laboratory:* anemia, bone marrow atypical lymphocytes, zinc sulphate 15 units, transaminase 91 units, BSP 10% retention. *Clinical Diagnosis:* lymphosarcoma. Expired August 16, 1957. *Autopsy Diagnosis:* lymphosarcoma.

Case 4: O. L., male, age 51 years. Ill since May 1957. Symptoms of fatigue, low grade fever. *Physical Examination:* findings of hepatomegaly, infiltration left hilum of lung; no jaundice or adenopathy. *Laboratory* studies revealed elevated transaminase, abnormal BSP dye retention, positive tuberculin skin test and positive histoplasmin skin test. *Clinical Diagnosis:* (1) acute viral hepatitis; (2) pulmonary carcinoma with metastases. *Liver biopsy* (surgical) revealed granulomatous lesion, histoplasmosis or Boeck's sarcoid.

Case 5: S. L., female, age 40 years; hospitalized on three occasions because of abdominal pain, hepatomegaly and fever. Had two surgical explorations with gallbladder removal and surgical liver biopsy. *Laboratory studies* revealed abnormal BSP dye retention and 3 plus cephalin flocculation test. *Liver biopsy:* Boeck's sarcoidosis of liver.

Therapeutic Considerations

It must be remembered that in all forms of acute hepatic disease that our treatment is generally nonspecific and empirical. I will not review all of the features of therapy but will discuss only a few of the controversial points. The problem of prolonged bed rest has been discussed, particularly since studies in Army and Navy Hepatitis Centers have indicated that ambulatory therapy results were just as good as prolonged bed rest therapy. Time will only tell whether this approach is correct or not. It is my personal feeling that a middle of the road approach should be followed at this time and that bed rest therapy should continue to be instituted in any given patient until the serum bilirubin falls to normal or levels off at a near normal level and until the urinary urobilinogen excretion is normal. Antibiotic therapy should not be considered in routine management, but if the patient remains febrile and the clinical course seems not to be particularly satisfactory, certainly antibiotic therapy is warranted. There are a number of reasons why such therapy may be beneficial. Perhaps first and foremost is that of the elimination of the bacteria from the alimentary tract or secondary systemic infections which may indirectly affect the liver. In addition to this there may be an unknown nutritional factor which may be of benefit to the patient with liver disease. Steroid therapy in acute liver disease continues to be a controversial problem. There are numerous reports which suggest that in the gravely ill acute hepatic disease patient steroid therapy may at times be life-saving. I would feel that it should be reserved for only the serious or critically ill type of patient and then be used perhaps as a last resort.

Supplemental therapy such as vitamins and the like are indicated. The use of massive doses of vitamin C, the administration of folic acid, and the administration of vitamin B_{12} may be of some empirical benefit. Certainly they would be of no harm, and if no other benefit is encountered other than to improve the appetite of a seriously ill patient, it would certainly be warranted.

Finally a few remarks regarding the criteria of healing of the acute hepatic disease patient. This is always a problem for the attending physician because he feels that he does not want to risk the possibility of the patient developing a chronic liver disease. If the serum bilirubin has fallen to a normal level and the urinary urobilinogen excretion is negative, the patient can be considered to have a return of liver function. Perhaps in the near future additional information from transaminase or other enzyme studies may give us more reliable criteria from the laboratory standpoint. With jaundice having subsided completely and the patient having a normal brom-sulphothalein dye excretion, one can assume that the liver is well healed. In an occasional case a repeat liver biopsy

may be warranted to determine the state of the hepatic infection, particularly in situations where the liver function tests were not too reliable from the onset.

In conclusion I would like to repeat that acute viral hepatitis is generally recognized by most clinicians, but other forms of acute hepatic disease are not considered. An isolated liver function abnormality, with or without jaundice, does not preclude a diagnosis of viral hepatitis. Numerous other etiological factors warrant consideration, as mentioned in this discussion.

North 68th & West Wells.

Suicide May Result from "Psychic Homicide"

Many persons who kill themselves may actually be the victims of "psychic murder" committed by their friends or relatives, according to a New York psychiatrist.

The persons who commit "psychic homicide" are not yet legally held responsible, but theirs is a crime usually committed by omission, Dr. Joost A. M. Meerloo said in the February issue of Archives of Neurology and Psychiatry.

"Psychiatrists agree," he said, "that punishment of parents or spouses or bosses is one of the most frequent motivations of suicide. This form of mental blackmail may be conscious in the suicide candidate or can be more subtly hidden behind many rationalizations."

But many other persons commit suicide because they are literally driven to it by someone with whom they identify. Doctor Meerloo said they commit suicide "because they were inadvertently aware of the wish or the command of their proxy that they had to die, though this 'homicidal' verdict had seldom been verbalized in a conscious way."

One case in which a person committed suicide on the unconscious demand of another person involved a man who refused to let his wife undergo treatment for a depressed state. He took a vacation with his secretary and his daughter, leaving his wife alone at home. After two days she committed suicide on his unconscious command. The husband remained unaware of his psychic murder.

Doctor Meerloo noted that the acting out of death wishes is usually not so obvious. However, the burden of inadvertent hostility and murderous wishes pushing those with weaker egos into depression and suicide is frequently seen.

"Especially in suicide by children," the author said, "we realize how much rejection, teasing and vituperation have to do with loss of self-esteem, and how these humiliations can drive the young person to suicide."

Doctor Meerloo related his concept of psychic homicide to that of brain-washing in which a person is made by another to believe, say and do things he himself would not ordinarily do.

In conclusion, he said, "In the age of encroaching technology and growing community pressure resulting in weakening ego, decreased self-esteem, and diminishing personal responsibility, these unconscious attacks on a person's will and integrity become more and more relevant."

Medical Film on Intramuscular Iron Therapy Available

Leading hematologists both in this country and England report on new indications for intramuscular iron in a film just released by the medical education department, Lakeside Laboratories, Inc., Milwaukee.

Called "Intramuscular Iron Therapy," the film had its professional premiere at the recent convention of the American Association of Blood Banks in Cincinnati, Ohio. The picture, in full color and sound, was filmed in England and the United States.

A highlight of the film is the radical reduction in blood transfusions during pregnancy achieved with a new iron-dextran complex administered intramuscularly.

The film "Intramuscular Iron Therapy" is available free on loan to state and county medical societies, medical schools and other interested medical organizations. It may be obtained from: Medical Education Department, Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin.

X-Ray Diagnosis of Diseases of the Esophagus*

By C. ALLEN GOOD, M. D.**

Rochester, Minnesota

ROENTGENOLOGIC examination of the esophagus is most often carried out by observing the act of swallowing while the patient stands. A thin mixture of barium and water is used to begin with, but this procedure may be supplemented later by watching the progress of thick paste or gelatin capsules filled with powdered barium. If the patient's complaint is dysphagia or if disease is found during this preliminary examination, additional roentgenoscopic observations should be made in the prone and supine positions. Roentgenograms are obtained to record abnormalities of structure, but abnormalities of function must be studied during the act of swallowing by means of the fluoroscope.

In the case of infants, especially those suspected of having tracheo-esophageal fistula, a water-soluble contrast medium should be used, and this should be instilled through a catheter introduced past the esophageal introitus. As a matter of fact, Pirkey and others have advocated the use of dilute water-soluble radiopaque substances such as iodopyracet (diodrast), sodium acetrizoate (urokon sodium) or a mixture of the sodium and methylglucamine salts of diatrizoate (renografin) for the examination of the entire gastrointestinal tract of infants.

Congenital Anomalies

Atresia is the most serious congenital anomaly of the esophagus. It may or may not be associated with tracheo-esophageal fistula. In such cases death ensues either from malnutrition or from aspiration of milk and water into the lungs. If the condition is recognized early 85 per cent of these patients can be treated surgically by establishing a primary end-to-end anastomosis.[1]

Examination of an infant during the first few days after birth is not easy, but if it is properly carried out an accurate diagnosis can be made. A small rubber catheter is introduced into the esophagus and about 1 cc. of opaque material is instilled. Under fluoroscopic guidance, roentgenograms are obtained in the upright and prone positions. If a blind pouch of esophagus is shown and gas is present in the stomach and intestines, a fistula must exist between the trachea and the inferior portion of the esophagus. If no gas is present the anomaly is atresia without fistula. On the other hand, a fistula may be present between the superior portion of the esophagus and the trachea, and this is best demonstrated by turning the infant into the prone position to allow the opaque medium to leak anteriorly into the trachea. Again, if gas is present in the stomach, another fistula must exist lower down between the trachea and the inferior portion of the esophagus. In some cases a fistula between the trachea and the esophagus may be present in the absence of atresia. This is best demonstrated by turning the patient into the prone position.

Other congenital conditions that may interfere with the swallowing mechanism in infants and children are those anomalies of development of the vascular tree, such as persistent right aortic arch, complete or partial vascular ring, and aberrant right subclavian artery, which impinge upon the esophagus and cause partial constriction of its lumen. Dysphagia is not always present in these cases and the anomalies may be encountered in adult individuals who have no complaints referable to the esophagus.

Extrinsic Masses

The lumen of the esophagus may be reduced in size by pressure of adjacent medias-

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**Section of Roentgenology, Mayo Clinic and Mayo Foundation (The Mayo Foundation, Rochester, Minnesota, is a part of the Graduate School of The University of Minnesota), Rochester, Minnesota.

tinal organs or tumors. Normally there is a small impression in the anterior wall of the esophagus caused by the arch of the aorta as it passes anteriorly and to the left. A similar but smaller impression is formed about 2 inches below this by pressure of the left main bronchus. Enlargement of the left atrium displaces the inferior portion of the esophagus in a characteristic fashion.

Among the tumors that commonly displace or impinge upon the esophagus are substernal goiter, aortic aneurysm, enterogenous cyst, and bronchogenic carcinoma with metastasis to the hilar and mediastinal lymph nodes.

Diverticula

Although diverticula may be found in any portion of the esophagus, there are three locations where they occur frequently. One of these characteristic sites is near the esophageal introitus where the fibers of the cricopharyngeus muscle cross in such a manner as to leave a small triangular portion of the posterior wall denuded of muscle. A pouch of mucosa may protrude through this space, forming a pharyngo-esophageal or Zenker's diverticulum. This is a false diverticulum, since there is no muscle layer in its wall. Such a diverticulum may become large and press on the posterior wall of the esophagus, compromising its lumen and causing dysphagia from external pressure as well as from the effects of regurgitating the contents of the sac into the hypopharynx.

A second common location is in the midportion of the esophagus at the level of the tracheal bifurcation. Diverticula at this site usually are small and cause no significant symptoms. It is said that some of them form because of adjacent lymph nodes which become attached to the wall of the esophagus and pull a small portion outward. Johnstone[2] has expressed doubt that there are very many of these so-called traction diverticula.

The third typical location is in that portion of the esophagus which lies just above the diaphragm. These epiphrenic diverticula, as they are called, may reach large size and cause symptoms of partial obstruction.

Achalasia

Achalasia or cardiospasm is caused by a failure of relaxation of the lower sphincter of the esophagus, the cardiac constrictor. As a result, ingested food and fluid pile up in the thoracic portion of the esophagus, the organ dilates, and the muscles of its wall lose tone. Very marked dilatation may lead to elongation and tortuosity. The condition can be recognized before ingestion of barium if there is present on the roentgenogram of the thorax a widening to the right of the shadow of the mediastinum, especially if a fluid level can be distinguished within it.

After ingestion of opaque material, the esophagus is found to be diffusely widened except as it nears the diaphragm and prepares to join the stomach. Here the lumen tapers gradually to a point. This tapering is a characteristic feature of achalasia and helps to distinguish it from carcinoma of the cardia involving the adjacent portion of esophagus. In the latter case the obstruction is more abrupt and usually the dilatation of the esophagus is less pronounced.

Diffuse spasm is related to cardiospasm but differs in that a longer portion of the esophagus is constricted. Frequently tertiary waves are present, giving the barium-filled esophagus a corkscrew appearance. Because a greater length of wall is involved dilatation is not a prominent feature, and when it does occur it is found above the level of the tracheal bifurcation. Diffuse spasm is often associated with regurgitant esophagitis and hiatal hernia.

Strictures and Webs

Strictures most often are produced by ingestion of a corrosive substance such as lye, or by the scarring incident to severe esophagitis such as that associated with esophageal hiatal hernia and chronic regurgitation. A stricture may be long or short and its lumen may vary from a diameter of 1 or 2 mm. to a diameter almost normal for that portion of the esophagus.

Webs are short bands or membranes that only partially occlude the lumen. They are found most often in the cervical portion of the esophagus, arising from the anterior wall. Often they are associated with hypochromic anemia and splenomegaly in undernourished women.

The roentgenologic examination in cases of web or stricture must be performed with care or the proper diagnosis may be missed. A thick paste should be used and the patient should be in a horizontal position. Each segment of the esophagus should be observed with care to determine that it dilates satisfactorily with the passage of the bolus. If no

lesion is found by this method, a barium-filled capsule may be given and its passage watched for points of obstruction. The size of the capsule can be varied depending upon the degree of obstruction suspected. The 000 size is commonly used. Thomas[3] advocated the capsule technic for the diagnosis of webs.

Hiatal Hernia

Herniation of a portion of the stomach through the esophageal hiatus is a common cause of symptoms. These symptoms, such as a sensation of food sticking or of fullness, may be associated with the act of swallowing, but they are more often associated with an esophagitis caused by regurgitation of gastric contents into the lower portion of the esophagus. When this occurs the patient may complain of pain in the thorax, of "heartburn" or of a sensation of pressure. If esophagitis becomes severe there may be an associated feeling of obstruction.

Three types of hiatal hernia are known: the sliding type, the para-esophageal type, and the type associated with shortening of the esophagus. The latter type may be on a congenital basis but in most instances develops as a result of long-standing regurgitant esophagitis.

A sliding hernia is best demonstrated by placing the patient in the prone position with the right side elevated from the top of the table—the right anterior oblique prone attitude. The patient is asked to swallow some of the barium mixture and then to hold his breath while straining—the Valsalva maneuver. As the opaque material outlines the inferior portion of the esophagus, it also demonstrates a small segment of stomach above the diaphragm. Some sliding hernias can be demonstrated if the examination is conducted with the patient standing, but others will be overlooked unless an observation is carried out with the patient in a horizontal position.

The chief roentgenologic feature of a sliding hernia is the fact that the junction of esophagus and stomach is situated above the diaphragm without any apparent shortening of the esophagus. Frequently there may be a slight constriction of the lumen at the point of junction.

A para-esophageal hernia differs from the sliding type by virtue of the fact that the esophagogastric junction is found in its normal position below the diaphragm while a portion of the fundus or body of the stomach extrudes through the hiatus and is situated in the thoracic cavity. This type of hernia is more likely to be present at all times, while the sliding type does, as its name suggests, slide back and forth. A combination of the two types may occur.

If the esophagus is short, a portion of the stomach is drawn up through the hiatus. The esophagogastric junction may be located at some distance above the diaphragm, and is usually recognized by the indentation in the outline of the column of barium produced by the constrictor of the cardia. While such shortening may be the result of an abnormality of development, it is thought that most instances are produced by the scarring and fibrosis of the esophageal wall secondary to severe or long-standing regurgitant esophagitis. Thus a sliding hernia may become a "short esophagus" hernia because of the regurgitation associated with it.

Scleroderma

Patients suffering from scleroderma may experience dysphagia, but the extent of the cutaneous manifestations has no correlation with the severity of esophageal involvement. Roentgenologic findings include prolonged transit time, abnormal patency, diminished peristaltic activity and, in some instances, narrowing of the lower segment. In those cases in which the involvement is most severe the esophagus may be short and a hiatal hernia present. All of the roentgenologic signs are more pronounced in the horizontal position since the passage of the bolus depends to a large extent on gravity.

Varices

Esophageal varices may be very difficult to demonstrate roentgenologically. Nelson[4] has said, "Unfortunately, even if radiologists avail themselves of the best equipment and techniques, they are at best only able to show varices in about 30 to 50 per cent of those patients known to have them."

The examination should be carried out with the patient in the horizontal position. Spot films made during roentgenoscopic observation afford the best method of demonstrating the engorged veins. The varices show best when the esophagus is in a resting state, for the passage of a peristaltic wave will obliterate them. Care should be taken not to fill the lumen with too large a bolus of opaque material. Although the Valsalva maneuver will efface varices in the

lower part of the esophagus, its use is of great value because it tends to eliminate primary peristalsis and during the period of relaxation after discontinuing it the varices fill and can be identified. It is at this moment that spot roentgenograms should be made.

Although varices can be demonstrated successfully with the aid of the ordinary thin mixtures of barium and water, the examiner will facilitate the procedure if he uses a thicker mixture having the consistency of clotted cream.

Tumors

Both benign and malignant tumors occur in the esophagus. Their roentgenologic characteristics are similar to those produced by the same tumors when they involve other tubular portions of the alimentary tract such as the colon or the small intestine.

Benign tumors may be intraluminal, pedunculated or intramural. The most commonly encountered are leiomyoma, fibroma, lipoma and enterogenous cyst. If intraluminal and attached by a long pedicle, the tumor may be mistaken for a foreign body. Those which arise in the wall of the esophagus produce a smooth crescentic defect in the column of barium with no disturbance of the mucosal pattern except for slight flattening of the longitudinal folds. The most common tumors to develop in this position are leiomyoma and enterogenous cyst.

Carcinoma of the squamous cell variety is the most common malignant tumor of the esophagus. In some instances adenocarcinoma develops in the lower segment, but this usually represents an extension from a carcinoma of the cardia. Adenocarcinoma may also originate in islands of heterotopic gastric mucosa which sometimes are found in the supra-diaphragmatic portion of the esophagus. Leiomyosarcoma is encountered infrequently.

The roentgenologic manifestations of carcinoma of the esophagus are (1) a short defect with abrupt ends, (2) constriction of the lumen, and (3) an irregular, ulcerated, or destroyed mucosal pattern. The lesion may be found in any portion of the esophagus from introitus to cardia.

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U. S. National Health Survey Reports on Acute Illnesses

About 438 million acute illnesses involving either restricted activity or medical attention or both occurred among the American people during the year ending June 30, 1958. The number of such illnesses averaged 2.6 for every person in the population.

The figures are from the newest report of the U. S. National Health Survey, which shows also that the incidence was highest in the youngest age groups and decreased progressively in each older age group. The rates ranged from an average of 4 illnesses among children under 5 to 1.6 illnesses per person 65 or over.

The incidence rate among females was slightly higher than for males.

Respiratory ailments accounted for 65 percent of all the illness involving medical attention or restricted activity. The respiratory illnesses caused 1,172 million days of restricted activity, or an average of 7 days per person. About half of this time involved bed disability.

The days of restricted activity included 219 million days lost from work, and 196 million days lost from school. The incidence of these illnesses reflects the impact of the Asian influenza epidemic which occurred during the year.

In addition to the respiratory illnesses, the survey covered infections and parasitic diseases, digestive system conditions, and injuries. The latter group includes fractures, dislocations, sprains, strains, open wounds, lacerations, contusions, and other current injuries. Data are given by age, sex, various severity criteria, and calendar quarter.

The new report, "Acute Conditions, Incidence and Associated Disability, United States, —July 1957–June 1958" is Public Health Service Publication No. 584–B6. Copies are for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 35 cents a copy.

Diagnostic Uses of Radioactive Isotopes

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THERE IS A MASS of literature on the diagnostic uses of radioactive isotopes, most of which is buried in some obscure journals which the ordinary practitioner does not have time to scan. The present article is meant to be a survey of some of the more practical uses of isotopes in diagnosis. No claims for original investigative work are made. The article is designed in outline form so that it may be quickly scanned. Portions with which the reader is unfamiliar may be quickly detected. Those with which he is familiar may be skipped.

Cobalt^{60}–Vitamin B_{12} Determinations

Blood transfusions and the use of preparations containing small amounts of vitamin B_{12} or intrinsic factor have obscured the diagnosis of some cases of pernicious anemia, and it is impossible to make a diagnosis without allowing the patient to have a relapse. Since B_{12} has been tagged with radioactive Cobalt^{60}, there have been designed four tests which measure the patient's ability to absorb B_{12} and consequently their possession or lack of intrinsic factor. Lack of intrinsic factor is a defect present in pernicious anemia. Without intrinsic factor the patient is not able to absorb B_{12} from the intestinal tract and therefore lacks an essential building block for the production of red blood cells. This results in pernicious anemia.

Fecal Excretion Test

Heinle, Welch *et al*,[1] determined the fecal excretion of Co^{60}–B_{12} in patients with pernicious anemia following a standard oral dose of .5 μgm. of Co^{60}–B_{12}. This test has the advantage in that it directly measures the nonabsorbed vitamin B_{12}, and it does not change the metabolic status of the patient if future tests are desired. It has the disadvantages of having to collect stool specimens for a week to 10 days. There is a possibility of losing some of the stool specimens. If a high excretion is obtained, it indicates no absorption has taken place. The test is then repeated and a capsule of intrinsic factor is taken just a few minutes prior to the test. This should correct the defect in absorption if the defect is pernicious anemia.

Schilling Urinary Test

The second was a test by Schilling.[2] An oral dose of 2 μgm. of Co^{60}–B_{12} containing about .5 μc. of Co^{60} was followed in 2 hours by a flushing dose of 1000 μgm. of nonradioactive B_{12} given intramuscularly. The principle is this: A normal individual will, in two hours after the oral dose of Co^{60}–B_{12}, absorb into the blood stream most of the dose. When the large intramuscular dose of nonradioactive B_{12} is given, some of the Co^{60}–B_{12} present in the blood will be flushed into the urine before the liver has a chance to absorb it. So a normal individual will flush a considerable amount of the dose into the urine during the 24 hours in which the test is run. The patient with pernicious anemia will not absorb the Co^{60}–B_{12} from the intestinal tract, so that when the large flushing dose is given, none will be flushed into the urine. The urine is very easy to process and the flushing dose of nonradioactive B_{12} rids the body of about ⅓ of the dose of radioactivity which the patient received. A disadvantage is that there may be an unrecognized loss of the urinary specimen, particularly in the first 8 to 12 hours of the test. This could falsify the conclusions. Impairment of the renal function will also affect the test by prolonging renal clearance.

If the patient excretes into the urine specimen more than 10% to 12% of the oral dose, the diagnosis of pernicious anemia is excluded. If values of less than 10% are obtained, the test should be repeated in a few days, but, with this variation: A capsule of intrinsic factor is given to the patient just prior to the capsule of radioactive B_{12}. The test is otherwise done exactly the same way. If the patient has pernicious anemia, this usually results in an increase in an output 4 to 5 times as high as on the previous determination. This value should have an absolute value of at least 8% to 10%. Sprue and other

malabsorption syndromes may show no increase or a very insignificant increase following the second test. Cases of gastric resection will show a correction such as pernicious anemia cases show. The dose of .5 μc. is 1/6 the amount permitted to be in the body at any given time and most of this is lost during the course of the test.

Liver Uptake Test

The third test described by Glass, Boyd, *et al*,[3] is based upon the uptake of radioactivity by the liver when the patient is given a standard dose of .5 to 2 μgm. of radioactive Co^{60}–B_{12}. The original technic requires a week of repeated assays. Some difficulties may arise in duplicating the liver projections on a patient on whom tests are repeated several times. Coexisting liver disease may also affect the results. A more rapid technic requiring only 48 hours, described by the same investigators,[4] requires the use of laxatives and enemas in order to rid the intestine of the residual radioactivity which is not absorbed. The measurement of hepatic uptake of radioactive B_{12} is based on the premis that B_{12} absorbed in the intestine is ultimately deposited in the liver. There it can be detected with a sensitive scintillation counter by scanning the cutaneous projections of the liver superficially, following oral administration of a tracer dose of radioactive B_{12}.

If the hepatic uptake is good, the test is considered completed. If no hepatic uptake is obtained, a second similar tracer dose is given orally, but, this time a potent preparation of intrinsic factor is given with it. The procedure is otherwise the same. The time for the single test is 2 days and if intrinsic factor has to be added in a second test, the time is 4 days. If the added intrinsic factor corrects the defect in absorption then a diagnosis of pernicious anemia is made. If it fails to correct the defect, malabsorption syndromes or sprue should be considered.

Serum Determination

The fourth technic—where the serum radioactivity is measured directly to determine whether or not the radioactive vitamin B_{12} has been absorbed—has certain advantages, but it is outweighed by its disadvantages. Very low counts are obtained in the serum which make the counting technics rather difficult since background activity is quite critical. Here, too, poor renal function will give erroneous results because of the low excretion rate.

Summary

In summary a few points should be mentioned. It has been definitely determined that the Co^{60} substance measured in the urine in the Schilling test is still vitamin B_{12}. The combination of Co^{60}–B_{12} with nonradioactive B_{12} must be carefully adjusted to obtain proper results. There is evidence that the efficiency of intestinal absorption decreases with increased uptake. There may be an intestinal B_{12} acceptor, similar to transferrin for iron. Glass, Boyd, *et al*,[5] have considered calling it B_{12} transferrin. The test will yield normal results in anemias due to blood loss, hemolytic anemia, and nutritional macrocytic anemias due to dietary deficiency of folic acid or B_{12}. Whereas, abnormal results are obtained in pernicious anemia in relapse, and in remission or in the preanemic stage, but abnormal results can be corrected in the second phase of the test by the addition of intrinsic factor. In sprue and in some cases of intestinal fistulas and other malabsorption syndromes, the defect cannot be corrected by the addition of the intrinsic factor.[4] Co^{60}–B_{12} is also being used as a measurer of liver function in patients not having pernicious anemia. There is, however, an overlapping of values and the limits of normality are not as yet well enough defined to make this a practical diagnostic test.

TABLE 1

	Pernicious Anemia		Gastric Resection		Sprue		Diarrhea	
	1	2	1	2	1	2	1	2
STOOLS	↑	↓	↑	↓	↑	↑	↑	↑
LIVER	↓	↑	↓	↑	↓	↓	↓	↓
URINE (Schilling)	↓	↑	↓	↑	↓	↓	↓	↓

Column 1 Indicates without intrinsic factor.
Column 2 Indicates with intrinsic factor.
An arrow pointing upward indicates increased radioactivity in the specimen and an arrow pointing downward indicates decreased radioactivity.

Blood Volume Determination

Physiologists are accustomed to dividing the various fluid compartments of the body into intracellular fluid space, interstitial fluid space, and vascular fluid space. Attempts to measure these various spaces by use of radioactive isotopes has been made, but difficulties have been encountered in

measuring a dynamic organism such as the body. Radioactive hydrogen tritium has been used to measure total body water. Radioactive sulphur has been used to measure the interstitial space. Radioactive sodium has also been used for this purpose, but conflicting results have been obtained and now the investigators using these methods refer to the sulphur 35 space or the sodium 23 space. These latter substances have not as yet been adapted for clinical use.

Radioactive Iodinated Serum Albumin

Human albumin was tagged with radioactive iodine. It was felt that the albumin space would conform to the plasma space and the measure of dilution after injection of the albumin could be used to measure the plasma volume. The difficulty is that the albumin sometimes leaks from the circulation giving a false impression of a higher plasma volume. The procedure for this determination is rather simple and under most conditions good results for clinical purposes are obtained by use of the method. The method is as follows: A small calibrated dose of radioactive iodinated serum albumin (RISA) is injected into a container of standard volume, such as a 1000 ml. volumetric flask. A similar dose is injected into the patient. After 15 minutes, a sample of blood is withdrawn from the patient and another sample is drawn from the container of known volume. The radioactivity of the plasma in the blood specimen is determined and the radioactivity of the fluid in the volumetric flask is also determined. Because the same amount of radioactivity was injected into the standard as was injected into the patient, a simple equation can be used to determine the albumin space or plasma volume of the patient. It is as follows:

$$P\,A \times P\,V = S\,A \times S\,V$$

P.A. Radioactivity per ml. of patient's plasma

P.V. Plasma volume of patient

S.A. Radioactivity per ml. of standard

S.V. Standard's volume 1000 ml.

THEN:

$$P\,V = \frac{S.A. \times 1000}{P.A.}$$

If a hematocrit determination is also performed from the sample removed after 10 to 15 minutes of mixing, the following equation may be used:

TOTAL BLOOD VOLUME x (1–Hematocrit) = P.V.

TOTAL BLOOD VOLUME – P. V. = RED CELL MASS

So apparently the two components, plasma volume and red cell mass, and the total blood volume can be obtained by this method.

Chromium[51]

Radioactive chromium as sodium chromate has been used to tag the red blood cells as a means of determining the red cell mass directly. The principle of the test is the same as the previous test using the albumin in that a known amount of radioactive red blood cells is injected into a standard and the same amount is injected into the patient. The test is performed as follows: A sample of the patient's blood is withdrawn and incubated with radioactive chromium. Chromium during the incubation period forms a reasonably permanent label on the cells. These can be reinjected into the patient. (Some people prefer to have a bottle of O negative tagged cells already prepared with the radioactive label and use those on all patients on whom they are doing blood volume determinations that day. The tagged cells are prepared in the morning and can be used on all patients on whom blood volumes are ordered that day, since the O negative cells are usually compatible with most patients.) If a known alliquot is injected into the patient and the same amount into a volumetric flask, the equation is the same as in the plasma volume, except that the red cells are measured and the result is red cell mass. The substitutions in the formula would be different, of course, since the red cell mass is equal to the total blood volume times the hematocrit. Total blood volume, red cell mass, and plasma volume are then obtained.

There has been some criticism in that the whole body hematocrit is not the same as the peripheral hematocrit. The hematocrit for some internal organs is lower than the peripheral hematocrit. Corrections for this are made by multiplying the peripheral hematocrit by .895. However, if both the plasma volume using RISA and the red cell mass using radioactive chromium are determined simultaneously, then such corrections are not necessary. Such refinements are usually not necessary for clinical purposes. If blood volume is determined before surgery and the course followed after surgery by the same

Table 2—Comparison of Findings on Three Blood Determinations in Various Conditions

Condition			
Burns	Decreased	Normal or increased	Normal or increased
Shock	Decreased	Normal or increased	Normal or increased
Vomiting and Diarrhea	Decreased	Normal or increased	Normal or increased
Acute Bleeding	Decreased	Normal	Normal
Over transfusion	Increased	Normal	Normal
Chronic bleeding	Decreased	Decreased	Decreased

method, comparable values are obtained, which is the important thing in treating the patient.

Incidentally, the advantage of these radioactive methods over the Evans Blue method is that determinations can be repeated. A sample of blood is withdrawn prior to the injection of radioactive material to determine body background radioactivity just before each test. As many as ten determinations can be done on the same patient.

It might be mentioned that the RISA values for plasma volume compare rather closely with the Evans Blue method. The reason for this is perhaps that the Evans Blue dye attaches itself to the albumin molecule after it is injected. So in one case we have the albumin tagged with radioactive material and in the other with a dye. Determination of the total blood volume gives the clinician a third dimensional picture of the patient's status, whereas determination of the hemoglobin, hematocrit, and red blood count gives only a two dimensional picture. These latter three determinations tell only the concentration of the component measured per 100 cc. The chart above demonstrates where the determination of total blood volume gives a truer representation of the clinical status of the patient than either the hemoglobin or the hematocrit.

Rose Bengal Test

This is a test designed to measure liver function[6]. The dye, rose bengal, has long been used as a measurer of liver function; but since it has been tagged with radioactive iodine, it has become more useful than previously. The rose bengal dye is concentrated by the liver parenchymal cells and the degree to which the dye is concentrated is a measure of liver function. After the dye is concentrated by the parenchymal cells it is excreted in the biliary tract into the intestine. Whether or not the dye is excreted can be used to determine whether an obstruction of the biliary tract is present. When this test was originally designed, experiments were performed on rabbits. A scintillation detector was placed so as to measure the amount of radioactivity in the liver. The dye was then injected into the rabbit. If the function of the rabbit's liver were normal, the dye would be picked up and excreted at an average rate. If the rabbit were treated with carbon tetrachloride prior to the administration of the radioactive dye, the parenchymal cells would not be functioning properly and would fail to pick up the dye. If the rabbit's common bile duct was tied, the liver parenchymal cells would pick up the dye, but would be unable to excrete it. The rate at which the radio-

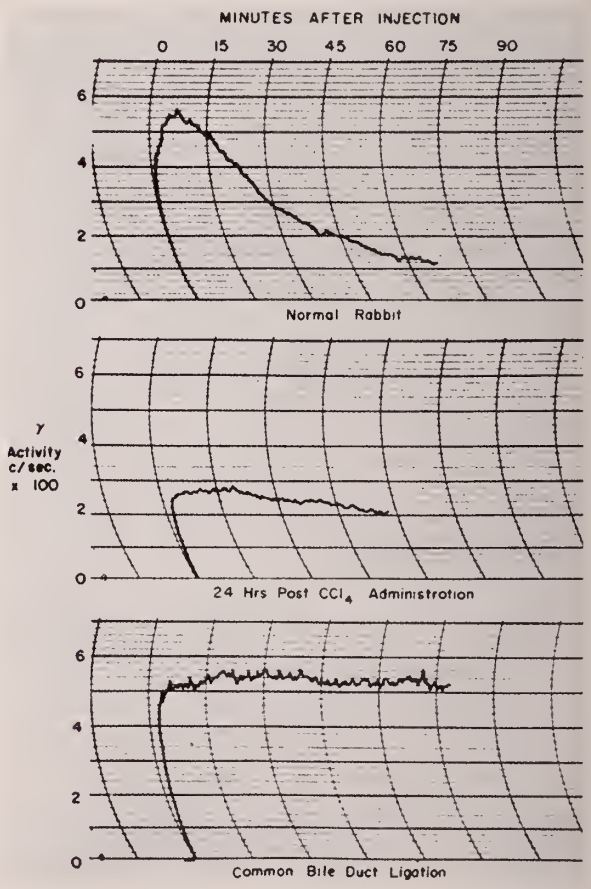

Fig. 1—Typical rose bengal liver uptake-excretion patterns in normal and abnormal rabbits. (Reprinted with permission from: Taplin, George V., *et al.*: The radioactive (I^{131}-tagged) rose bengal uptake-excretion test for liver function using external gamma-ray scintillation counting techniques, J. Lab. & Clin. Med. 45:665–678 (May) 1955.)

active material was concentrated and released from the liver could be determined by attaching the scintillation counter to a rate meter and determining the radioactivity in the liver over a period of time. While the study revealed good results in the rabbit, on clinical application many overlapping curves were obtained. It will, however, prove useful as any other single liver function test and perhaps will represent a valuable component in any battery of liver tests which are performed. A recent modification includes giving the patient a very fatty meal after the liver has concentrated the dye. If the patient has no obstructive lesion, the liver quickly flushes the radioactive material in the biliary system into the intestine. If an obstruction is present, however, this is not accomplished.

Iodine^{131} Test of Thyroid Function

Iodine^{131} Uptake

A battery of tests using I^{131} to measure thyroid function have been designed since the original iodine uptake test. The normal thyroid gland will concentrate iodine 30 times more so than any tissue of similar weight. The normal gland will pick up an average amount of iodine ranging from 15% to 45% of the dose administered orally. If the gland concentrates less than 10% it is considered to be poorly functioning. If it concentrates over 50% it is considered to be hyperfunctioning. These principles appear quite simple, but a number of factors have crept into the determination and into the interpretation of results which have complicated these rather simple principles. Medications which interefere with the performance of the test are: Lugol's solution, potassium iodide, cough syrups containing iodide (asthmatics frequently take these medications for long periods of time), hormones, vitamin preparations containing iodide, ointments and tinctures containing iodine, thiocyanates, x-ray procedures using iodized dye, antiparasitic drugs which contain iodides, thyroid extracts and thiourea derivatives and more recently tolbutamide (Orinase). Some of these iodinated substances compete with the radioactive iodine, others saturate the gland so it will not accept any additional iodine. Thiocyanates interfere with the ability of the gland to pick up the iodine. Thiourea derivatives interfere with the conversion of iodine to form the thyroid hormones. There are also pitfalls in the actual determination, such as columnation of the detector, the presence of ectopic thyroid tissue and other difficulties that may be corrected by the use of filters or a spectrometer.

In the interpretation there are still other difficulties encountered. Patients with an acute thyroiditis may show all the symptoms of toxicity and have an elevated basal metabolic rate and an elevated protein bound iodine and yet from 0% to 1% uptake of I^{131} by the thyroid gland. The results of the test are not erroneous, it is only the interpretation which may be erroneous. The gland is actually not concentrating iodine which is what we are measuring its ability to do. Yet the patient is toxic due to the presence of iodinated compounds being released into the blood stream from the inflamed disrupted thyroid gland. A large colloid goiter may concentrate an amount of iodine above average values due to its bulk; however, the poorly functioning tissue will not turn the iodine into active hormones very quickly and the protein bound iodine and basal metabolic rate may be within normal limits. Here again, these tests indicate only the uptake of iodine by the thyroid gland and not the physiologic status of the patient. It is not the test that is wrong, but the interpretation of the results that may be erroneous. It might be mentioned that the two types of myxedema, both primary and secondary, may be differentiated by the iodine uptake. If the myxedema is primarily due to thyroid gland failure to function, no effect on the uptake will be obtained by the administration of thyroid stimulating hormones prior to the iodine uptake. However, if the defect is secondary due to deficiency in thyroid stimulating hormone production by the pituitary, then the uptake will be increased if 40 U.S.P. units of thyroid stimulating hormones are given for about 3 days prior to the uptake study. In secondary myxedema the increase in uptake may exceed the original by 15% or more.

Iodine uptakes may be performed at various time intervals after the administration of the oral dose, such as 6 hours, 8 hours, 24 hours, 48 hours, etc. The rate of iodine uptake may be of further diagnostic value. Intravenous iodine uptakes are also performed and these, too, may be of value in particular circumstances.

Protein Bound Iodine^{131}

The protein bound iodine^{131} (PBI^{131}) deter-

mination can also be a very useful test. Some authorities feel that it is more reliable as an indication of thyroid function than the iodine uptake. Usually this is done at 24 hours after the oral administration of I^{131} on a sample of blood withdrawn at the same time the iodine uptake is measured. The blood serum is measured for its radioactivity; and then a protein fraction of the serum is made and this is also measured for its radioactive content. The ratio of the radioactive iodine in the protein fraction as compared to the total serum radioactive iodine content is an indication of the ability of the gland to form thyroid hormones. The protein bound fraction actually represents iodine that has been picked up by the thyroid gland and converted to thyroid hormone during the 24 hours in which the test is run. Some investigators suggest the use of the 72-hour PBI^{131} determination since, at this time, most of the inorganic iodine has been lost from the circulation and is not a factor in the calculations. While the 72-hour PBI^{131} may be a somewhat more accurate test, nevertheless it is inconvenient to have the patient return for an additional visit. It is more convenient to have the patient's blood drawn at the same time as the iodine uptake is done, at 24 hours.

Salivary Iodine^{131}

It was found that the salivary gland has quite a propensity for concentrating inorganic iodine which is circulating in the plasma. It was first thought that the salivary glands had a hormonal relationship which worked inversely to that of the thyroid gland. In other words, the salivary glands would concentrate more iodine while the thyroid gland was concentrating less, or they would concentrate relatively less when the thyroid gland was concentrating more. It was found that what was occurring was simply a concentration of the circulating inorganic iodine by the salivary glands. If the thyroid gland were concentrating large amounts of iodine or converting large amounts to protein bound iodine, then the salivary glands would secrete relatively less radioactive iodine. An inverse relationship would be present if the thyroid gland were underfunctioning. So the ratio of salivary I^{131} to serum PBI^{131} was determined as a method of measuring thyroid function. The differences between the normal and the abnormal were exaggerated due to the ability of the salivary gland to concentrate the nonradioactive I^{131}. It became a more valuable tool than the ratio using total serum I^{131}. Many feel that this is particularly useful in diagnosing hypothyroidism.

Urinary Iodine^{131}

The determination of excretion of I^{131} into the urine has not been used extensively except in cases where residual metastatic carcinoma is suspected. Usually 48 to 72-hour specimens must be obtained in order to obtain all of the iodine that is excreted. If the thyroid gland has been completely excised for cancer therapy and more than 10% of the dose is still retained by the body and not excreted in the urine, then it is presumed that there may be functioning thyroid tissues somewhere in the body concentrating the iodine. Some practitioners will further treat a patient for metastatic carcinoma if they show less than 90% excretion of the dose, providing their thyroid gland has been completely excised. The test, however, has not been popular as a means of differentiating hypo- or hyperthyroidism.

In Vitro Radioactive Triiodothyronine Uptake By Erythrocytes

Hamolsky, Stein, and Freedberg reported on the uptake of radioactive triiodothyronine (labeled with I^{131}) by erythrocytes in the various states.[7] I^{131} labeled triiodothyronine is added to whole blood in vitro and incubated. The radioactivity is measured on the separated and washed red blood cells and calculated as percentage of whole blood radioactivity corrected to a hematocrit reading of 100. Euthyroid patients averaged about 13.9% uptake. Hyperthyroid patients averaged 21.8% and hypothyroid patients averaged about 9.3%. Several hypotheses are put forward to explain the differences in uptake. There is possibly a qualitative difference in the specific binding protein for thyroid hormone in the different states of thyroid metabolism; or there may be alterations in the protein inter-relationships in the plasma in the various thyroid states, which differently affect tissue incorporation of the hormone; or there may actually be quantitative differences in the thyroxine binding globulin of the plasma. In any event it may represent a satisfactory test for determining thyroid function without administering any radioactive iodine directly to the patient since the determination is made in vitro on the blood re-

moved from the patient. The test is apparently not influenced by the administration of any organic or inorganic iodinated compounds other than thyroid hormones. This makes the test valuable in cases where either the iodine uptake or protein bound iodine test may be influenced by such factors, where this test would not be. The difficulty is that the radioactive iodinated triiodothyronine is rather expensive.

Iron Metabolism Using Fe^{59}

Radioactive iron can be used to study the metabolism of iron in the body, *i.e.*, its absorption and distribution. Also, because of its incorporation into the hemoglobin complex, it is a valuable tool in studying the manufacture of red cells.

Moore, Dubach, *et al*,[8] studied the intestinal absorption of ferrous and ferric iron by normal and anemic subjects with radioactive iron. They found that all subjects absorbed ferrous iron more readily than ferric iron (ratio 1½ to 15 times greater for ferrous iron).

The same groups in 1955 reported on the distribution of iron in humans and showed that the calculated iron excretion in the feces in normal subjects was .33 to .52 mg. per day. For iron deficient patients it was .03 to .06 mg. per day. For a woman with hemolytic anemia it was 1.45 mg. per day.[9]

Many studies have been done on the turnover of iron in hemochromatosis. Bothwell, *et al*,[10] investigated four cases of hemochromatosis and eleven normal patients. They found the mean plasma iron turnover was significantly raised in hemochromatosis while the red-cell turnover was normal. The percentage of the dose of radioiron used for hemoglobin formation was less in hemochromatosis. Repeated phlebotomies were well tolerated and caused a marked and sustained plasma iron turnover. The red-cell iron turnover appeared also to be increased and the percentage of the dose utilized was raised, although it was still lower than normal.

Several studies[11,12] have been done on the plasma clearance and red cell utilization of Fe^{59}. Since about 21 mg. of ferrous iron is a daily requirement for hemoglobin production and that circulating in the plasma is only about 3 mg., then iron must enter the plasma from the spleen and other reticulo-endothelial spaces at the same rate at which it leaves to be incorporated into red cells.

The rate of iron clearance from the plasma must, therefore, represent a composite of all pathways involved and a reflection of the functional status of hematopoiesis. Exceptions are in the cases of pernicious anemia and Mediterranean anemia where iron is stored but not used. A more direct and accurate index of hematopoietic activity is the rate of incorporation of iron in the newly formed red cells.

To determine the plasma clearance inject about 4 mg. of Fe^{59} citrate and obtain samples of blood at 5, 15, 30, 60 and 120 minutes after injection. Determine the plasma activity and plot the values, on semilog paper, against time. By extrapolating to zero time with the curve, the disappearance or turnover halftime is determined. Obtain blood samples at 3, 7 and 14 days and determine red-cell incorporation of Fe^{59}.

Normally the plasma halftime is from 1 to 2 hours. In iron deficiency, hemolytic disorders, and polycythemia where there is a rapid turnover of Fe^{59}, it is only .3 to .5 hours. In aplastic anemia it is 2 to 4 hours. In the exceptions of pernicious anemia and Mediterranean anemia the turnover is also rapid, .3 to .5 hours. However, the rate of incorporation into the red cells tells a more accurate story of hematopoiesis. Where there is about a 90% uptake by the red cells in one week in normal subjects there is a value approaching 100% in 3 to 4 days in iron deficiency cases. In aplastic anemias and in pernicious anemia and Mediterranean anemia as well, there is a slow rise over many weeks as the iron is slowly incorporated.

Red Cell Survival

In determining the red cell survival, a dose of about 100μc. of radioactive chromium is used. The blood is withdrawn from the individual to be studied and tagged the same as in the procedure used for red cell mass determination with Cr^{51}. The cells are withdrawn and incubated with Cr^{51} and then reinjected into the patient. An alliquot is saved for the measurement of the amount of total radioactivity injected. In this way the blood volume can be determined at the beginning of the procedure. Samples of blood are withdrawn periodically over the next 5 to 6 weeks and calculations are made to allow for 1% loss of Cr^{51} from the cells daily during the period of the test. While the Cr^{51} is a rather permanent label, about 1% is eluted per day from the cells by loss, other than by red cell destruction. The remaining Cr^{51} remains

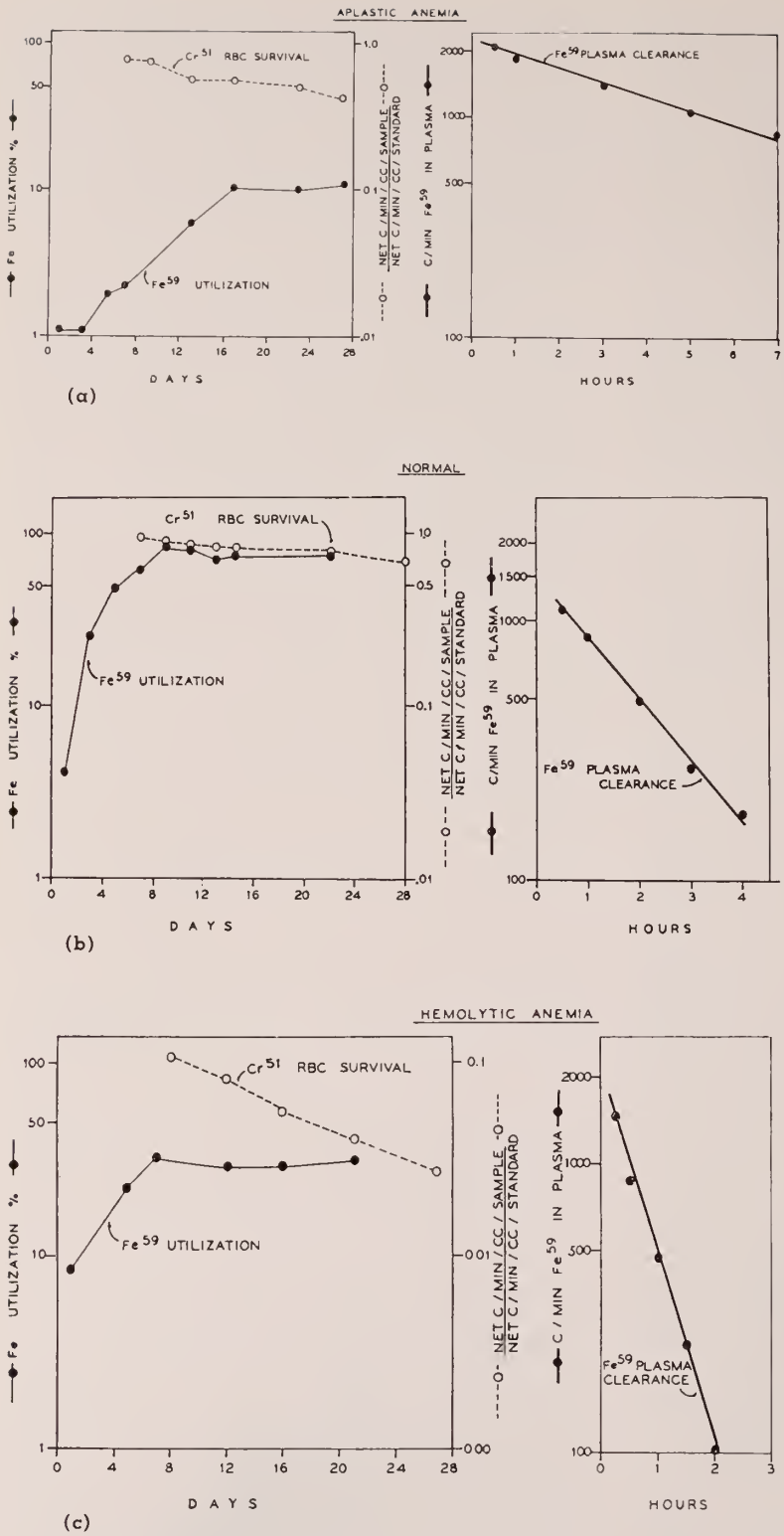

Fig. 2—Typical curves for radioiron plasma clearance, radioiron utilization by newly formed erythrocytes, and survival time of a mixed population of radiochromium-tagged erythrocytes: (a) in a subject with idiopathic aplastic anemia, (b) in a normal subject, and (c) in a subject with a hemolytic anemia. (Reprinted with permission from: Weinstein, Irwin M., and Beutler, Ernest: The use of Cr^{51} and Fe^{59} in a combined procedure to study erythrocyte production and description in normal human subjects and in patients with hemolytic or aplastic anemia, J. Lab. & Clin. Med. 45:616–622 (April) 1955.)

tagged to the cells until the cells are actually lost from the circulation. Using this technic about half the cells will be found to have disappeared from the circulation anywhere from 28 to 49 days after the beginning of the test. In severe hemolytic anemia halftime survival will be in the vicinity of 10 days. In some patients who have had a splenectomy their survival time may be over 40 days. The test is of most value in differentiating between patients with hemolytic or aplastic anemia. Weinstein and Beutler[12] used Cr^{51} and Fe^{59} in a combined procedure to study erythrocyte production and destruction in the normal human patient and patients with hemolytic or aplastic anemia. The three graphs at the left present their findings. The markedly shortened survival time in hemolytic anemia with normal survival time in the other conditions will be noted. The more rapid iron utilization in hemolytic anemia and the poor utilization in the aplastic anemia will be noted in the same graphs.

Fat Digestion and Absorption

The fat molecule, triolein, has been tagged with I^{131}. If this is administered orally to a normal person, the triolein is broken down

to fatty acids and glycerol. The fatty acid portions of the molecule which have been tagged with I^{131} are then absorbed. Radioactivity then appears in the blood stream about 4 to 6 hours after the oral dose. Only traces of radioactivity are found in the stool. If, however, the total blood radioactivity is low and the stool activity is high, there are two possible circumstances which may be present.

There may be poor pancreatic function which interferes with the breakdown of the fat molecule for absorption or there may be poor intestinal absorption of the digested molecule in the presence of normal pancreatic function. If an abnormal result is obtained in the first phase of the test, a second phase is carried out. In the second phase the fatty acid, oleic acid that is tagged with I^{131}, is used instead of the triolein. The test is otherwise the same. The blood is tested for the appearance of radioactivity 4 to 6 hours after the oral dose and the stools are collected for several days and tested for radioactivity. If in the second phase of the test there is increased radioactivity in the blood and practically none present in the stool, it can be assumed that the defect is due to pancreatic malfunction. Chronic pancreatitis, carcinoma obstructing the duct of the pancreas, or stones obstructing the pancreatic duct are all causes of poor pancreatic function. If, however, there is no appearance of radioactive material in the blood and there is a fairly large amount present in the stool, then it would be assumed that there is poor intestinal absorption of the fatty acids. Fatty acid molecules, such as oleic acid, should be absorbed intact and poor pancreatic function is not a factor in their absorption. Therefore, poor pancreatic function or poor intestinal absorption may be diagnosed with this two-phased test.

550 N. Dewey Street.

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Comparison of Neighboring States . . .

Communicable Disease Scoreboard for the Month

States	Poliomyelitis			Diphtheria			Whooping Cough			Scarlet Fever			Measles		
	New Cases	Total to Date	Total* This Time Last Year	New Cases	Total to Date	Total* This Time Last Year	New Cases	Total to Date	Total* This Time Last Year	New Cases	Total to Date	Total* This Time Last Year	New Cases	Total to Date	Total* This Time Last Year
Wisconsin	2	62	214	0	1	2	101	1,160	657	248	6,784	5,100	198	73,358	3,773
Illinois	6	239	346	0	9	3	49	896	769	148	3,130	3,647	225	24,098	9,896
Iowa	3	70	85	0	14	12	.....	.....	191	.....	.....	1,417	976	12,062	9,663
Michigan	8	1,221	508	0	6	38	61	1,149	1,326	258	5,026	6,991	345	40,525	18,925
Minnesota	0	32	55	3	70	35	.....	.....	52	.....	.....	904	9	1,328	8,096

Figures are based on states reporting for the period Nov. 30—Dec. 13, 1958, except for whooping cough and scarlet fever which are for the period Nov. 23—Dec. 6
.... Report unavailable at time of publication.
*Estimated to nearest calendar week.
The above statistics taken from Patterns of Disease, January, 1959.

A New Look At Tuberculin Testing

By AGNES JENSEN, R. N.*
Madison, Wisconsin

THE TIME HAS come for a closer look at the tuberculin test as an aid to tuberculosis control and eventual eradication.

These are the words of Floyd M. Feldmann, M.D., in an article published by the *National Tuberculosis Bulletin* in October 1955.

To a great extent this statement also expresses the viewpoint of the Wisconsin State Board of Health. Tuberculin testing, which enjoyed great popularity in the 1930s, had assumed a less important role with the advent of miniature x-rays. Another factor was the realization that a case-finding tool which yields large numbers of suspects (10 to 15 per cent in school children and 25 to 30 per cent in University of Wisconsin students in 1935), yet who were not confirmed as having the disease for which they were screened, was of questionable value.

Recently, especially during the past five years, we have seen a renewed interest in tuberculin testing as a screening method for tuberculosis case-finding. This interest has been stimulated by a variety of factors. First, the rate of tuberculin reactors in Wisconsin school children has decreased from the 10 to 15 per cent previously mentioned to 5 per cent or less, and from 25 to 30 per cent to 10 per cent in University of Wisconsin students. This makes it possible and more practical to use this test for selecting a small but highly suspect group consisting of reactors and their household contacts for further investigation.

Second, mobile chest x-ray surveys in Wisconsin have become very slightly less productive of tuberculosis in general population groups in recent years. This is due partly to the hoped for and expected decrease in the rate of active cases; to a greater extent, it is due to the fact that certain segments of our population readily accept the chest survey services and are x-rayed and re-x-rayed in succeeding surveys, while another segment—made up largely of older age groups, persons in the lower income bracket, and those who believe that they may have tuberculosis—is reluctant to be x-rayed. Admittedly, special educational means must be sought to reach these groups; but we also believe that a positive, first discovered tuberculin reaction in a child not previously tested, or in a child known to have converted from a nonreactor to a reactor, is an excellent entry to the homes of some of the persons in the group resisting mass x-ray surveys. As a result, it leads to the discovery of active cases which might otherwise escape detection.

Third, periodic testing of selected groups makes it possible to judge the prevalence of tuberculosis by giving us infection rates, and consequently can be used to measure the success of control programs. This factor also was noted in a Kansas City study, discussed in the *American Review of Tuberculosis and Pulmonary Diseases* (November 1958), which points out the close relationship between tuberculin skin sensitivity rates and mortality rates. This experience bears out our point that high sensitivity rates, or an increase in sensitivity rates, indicates the presence of active cases of tuberculosis in the community.

The availability of drugs for the treatment of tuberculosis increases the value of planned periodic tuberculin testing. Knowledge of the time at which a nonreactor converts to a tuberculin reactor enables the physician to decide whether to institute therapy in the new reactor.

For these reasons, the State Board of Health has attempted to stimulate local public health nurses and health departments to re-appraise the value of the tuberculin test, restoring it to full effectiveness in tuberculosis case-finding. The Division of Tuberculosis Control has been emphasizing the results of recent studies and developments regarding the importance of uniformity of solution strength, proper dosage, and intracutaneous administration. The use of uniform criteria for reading reactions and technique of measuring such reactions, as well as the points just mentioned, are fundamental to the proper use and interpretation of the tuberculin test. Only in this way can we obtain satisfactory effectiveness of this case-finding tool.

*Public Health Nursing Consultant, Division of Tuberculosis Control, Wisconsin State Board of Health.

Editors—
HARRY BECKMAN, M.D., Marquette University, Milwaukee
F. E. SHIDEMAN, M.D., University of Wisconsin, Madison

Comments on Treatment

Must All the Drugs Be Used?*

By HARRY BECKMAN, M. D.
Milwaukee, Wisconsin

LET US SUPPOSE for the moment that all the claims made for a new drug are true, that with it we can do this or that, as alleged by its proposers. There still remains the question: Do we want to do all these things? Shall we tranquilize the patient merely because the means are at hand, or alert and stimulate him, willy-nilly, when he is deluded or obsessed? Do we really want to lose control of all our mild elderly diabetics through a fistful of pills? Are we to go on creating more resistant infections through giving each new antibiotic a whirl? Shall we blindly accept the asseveration that two drugs with opposing types of action invariably give a nice blended effect when used together in fixed proportions? Do we need to risk orthostatic hypotension, ileus, visual disturbances, palpitation, paresthesias, etc. merely to obtain blood pressure reduction in a mildy hypertensive patient? How frequently is intravenous iron administration advisable? Do we want often to replace thyroid substance with a quicker-acting compound whose omission may cause distressing withdrawal symptoms? And so on and so on.

Do we really need all the time all the things that all the new drugs will give us? With full realization of the probable absurdity of the comparison, I am nevertheless going to liken political man's possession of his new military weaponry with medical man's acquisition of his new pharmaceutical arsenal. The time is not yet here when the decision will have to be made whether to drop the hydrogen bomb or not to drop it, but all the world is quivering with fear that such a moment is imminent, and men of good will everywhere are agitating for restriction of the use of this dreadful new power to only those activities of mankind wherein his best survival interests can be selectively aided. To use or not to use the new drugs for all they can do, that too is a question, our peculiar and particular medical question, and ours the solemn responsibility to answer it. For progress in this field will not be halted, and we are only now crossing the threshold into the vast drug sales room of the near future, whose walls and floors and counters and chests and racks and shelves will be loaded with bottles crying out "Use me! Or me! Or me! Or all of us together!" Shall we do it, always in all cases, all of it? Money in immense amounts is invested in the effort to tell us that this is our duty; the symptom is there, the drug is, or soon will be, available; the two must meet head-on invariably. "Treat your patient with these new drugs, Doctor, treat him, each one of him, as is now your duty, or else a new kind of physician will be created who *will* do it." This is exaggeration, of course, but even in such exaggeration there is truth. We are soon to acquire, through investigations now actually under way, such power through drugs over the metabolic processes in human tissues as will make the nuclear fission products seem puny in their potentiality for control of the world.

We doctors, while we still retain that measure of control over our practices allowed us by the inspired popular clamor of patients to be dosed, must make the decision whether to give up all along the line and merely hand out the pills, or not. No individual can *dictate* that decision, but I shall here attempt to *influence* it by saying this much: All drugs —even the very best and least noxious of them—are, psychologically or physically, potentially toxic agents; and none of them should be used unless such use cannot reasonably be avoided.

*Portion of a paper read on August 13, 1958, at the meeting of the National Medical Association in Milwaukee, Wisconsin, and on November 13, 1958, at the meeting of the Interstate Postgraduate Medical Assembly in Cleveland, Ohio.

2831 North Shepard Avenue.

The President's Page . . .

PATTERNS, PORTENTS AND PARADOXES

PATTERNS in medical practice for 1959 and the next decade seem destined for change. While it is a gamble to predict the future, it is certain that many changes will occur in the next ten years which will equally affect specialists and generalists. We certainly hope that the net result will be a favorable balance of good over bad.

Medical schools will probably turn out more generalists. They will have longer training and be internists in fact if not in name. The solo practitioner will be rare, both in urban and rural areas. Community-wide schedules of fees are a definite concept for the future, in order to compete with the growing health centers of the labor unions and prepayment panel plans. Since fee schedules will tend to be relatively fixed, fewer physicians will have unusually high or unusually low income. Collections will be better because of more widespread health insurance coverage which, incidentally, will bring increasing loads of paper work. More and more hospitals will have salaried staffs although private practice wings will be available for members of their attending staffs. In large cities physicians will, therefore, probably affiliate with only one hospital. Medical school training will probably remain about the same for some time to come, but residency training for the generalist and specialist will undoubtedly be lengthened.

PORTENTS, or less favorable predictions for the future of American medicine, are with us as never before in this era of unbelievable confusion of human ideas. Begun in 1935, the Social Security Act devised a new taxing system in addition to the income tax, and it promised "insurance" benefits to employes and employers covered by the Act. In spite of our opportunity to observe the fate of medicine in the socialistic countries of Europe and Britain's classic example of a welfare state in action, our Congress has repeatedly passed bills since 1950 amending the Social Security Act and bringing our national government closer to the American welfare state. The climax of these amendments was H.R. 7225, a plan which brought the medical profession directly into the "insurance" part of the Social Security Act. Legislation providing for medical certification of total disability, military dependents' medical care, veterans' nonservice connected medical care, and others unquestionably in my mind, portend the eventual nationalization of American medicine. Our profession has made in the past a good but unsuccessful fight to defeat these bills. Legislation is being currently introduced in the Wisconsin legislature which, if enacted, will alter radically the practice of medicine in our state and in some instances jeopardize the welfare of the patient. Your State Medical Society is vigorously opposing such legislation. I believe that those members of the State Medical Society who are not in the fight are more unaware and unsuspecting, than simply apathetic or despairing.

PARADOXES in our modern world of medicine face us on every hand. Modern medical training gives us a miraculous armentarium with which to combat human disease and decay and we dedicate ourselves to the quest of knowledge that may relieve suffering and prolong life. At the same time, the same science which produces the tools to heal perfects atomic warfare for mass decimation, not to speak of the even more destructive biological, bacterial and chemical warfare which could annihilate not only all of humanity but all animal and vegetable life on the face of this planet. Statistics prove that the public annually spends twice as much for tobacco, three times as much for alcohol and five times as much for recreation as it does for physicians' services, and yet we hear a cry about the high cost of these services. Contemplating the patterns, portents and paradoxes of the present and the immediate future makes it a bit difficult to be too optimistic. We can, however, continue to do our best in a great effort to change the pattern and to keep American medicine functioning in the American way.

William B. Weldenkamp M.D.

Certification for the Psychologist

According to the best definitions known, psychology is the study of the science of the mind, mental processes, sensations and desires—the science of human and animal behavior, actions, traits, attitudes and thoughts. A psychologist is a student of, or a specialist in psychology.

Psychiatry is the branch of medical science concerned with causes, symptoms and treatment of disorders and diseases of the mind, including psychosis and neurosis. A psychiatrist is a specialist in psychiatry.

In these definitions lie some fine subtleties which could be extremely helpful to both psychologist and psychiatrist—the psychologist dealing with the science of mental mechanisms and the psychiatrist dealing with medical disorders of the mind. Not so simple, but sharply defined and limited.

Let it be clear that the psychologist should never be included in the category of cultists and faddists. The psychiatrist looks on the field of psychology as a learned and highly essential part of the field of mental mechanics. We, in the field of psychiatry, feel that the psychologist has made many essential contributions in the field of mental processes without which the psychiatrist could not practice his profession. It is also tragic that the two fields should be torn by a strife that is possibly unnecessary and meaningless—two learned professions in the realm of the mind which apparently cannot or will not reach a "meeting of the minds!"

According to a 1955 report of the Commission on Psychology of the Conference on Psychotherapy and Counseling of the New York Academy of Science there were 13,000 members of the profession at that time. Of this number, 5,000 were working in clinical areas, half in academic work (teaching or research), others in hospitals, churches, schools and correctional institutions. About 400 were practicing psychotherapy as private counselors. The same source notes that "psychotherapy, historically, has fallen in the realms of religion, philosophy and education." During the last decades of the 19th century, American psychologists concentrated on the experimental, objective study of behavior, hence the accent on research methods and techniques in training and professional work. Applied psychology then developed as the attempt to use the scientific approach to aid in solving problems in child training, education, personnel adjustment and group relations.

The State Medical Society of Wisconsin has gone on record as opposing certification or licensure for the clinical psychologist, or for that matter, any member of the psychological group. This does not mean that the psychologist is not needed or not wanted by the medical profession. What is required, however, is a voluntary means by which the psychologist can be certified by his own intraprofessional board, thus providing recognition—both public and professional—to those who are adequately trained. Legislative certification produces a far different result.

The psychiatrist, just as the psychologist, constantly is on the alert for motivation. What purposes are to be gained from certification? What purposes are to be gained from licensure? The experience of most state medical societies and the American Medical Association, the American Psychiatric Association, and the American Psychoanalytic Association has been a sad one with regard to legislative certification or licensure among nonmedical scientific groups. An ancillary branch of the sciences which deals with the health of the human body, whether it is mental or physical, is likely to begin seeking its statutory recognition in a rather innocuous fashion. With legislative certification comes a tendency—evidenced in several of the paramedical fields—to take on added diagnostic and treatment functions without the training or skill of the unlimited licensee. These efforts lead, all too frequently, to a desire to serve as physicians without undertaking the training or acquiring the background required by public law of the Doctor of Medicine. To such persons it is difficult to make clear the responsibility of the physician to his patient or the physician's responsibility to the maintenance of the health of the public.

We feel that the clinical psychologist is not qualified in the area of psychotherapy since this is a distinct medical problem. Moreover, attempts to serve patients in this area interfere with the distinctive contribution which the psychologist is capable of making and which is needed. His training prepares him to assist in diagnosis, research and teaching in the field of human behavior. We need the psychologist to administer, interpret and evaluate psychological testing. We need the psychologist for research and experimentation. In research he is a scientific worker who is on his own responsibility, subject to medical judgment, as to patient's requirements.

Psychiatry is a branch of medicine. Psychotherapy is a medical responsibility. The medical profession is responsible for the health of the public. We want the psychologist as part of the psychiatric team. Legislative certification or licensure provides state sanction for the practice of psychotherapy by the psychologist, a realm of health care requiring medical supervision and direction.—EDWARD D. SCHWADE, M. D.

19th Century Medical History in Sheboygan

SECTION ON MEDICAL HISTORY

Dr. Joseph Kovacic, who has been practicing medicine in his native Sheboygan for the past 18 years, admits to a love of local history. For the past five years he has been busily ferreting out the fascinating story of medicine in his home county since 1834 when Sheboygan began as a sawmill site.

Recently Doctor Kovacic dispensed some medical history capsules before the city's Catholic Women's Charity Club, and the *Sheboygan Press* gave broad coverage to the talk.

In *Domestic Medicine*, a publication of 1834, Doctor Kovacic caught a glimpse of the home treatments of another age. The book suggested that a cause of most diseases was the closing off of perspiration. The evening air was always bad, the treatise cautioned, and even fresh air on dewy summer nights was to be avoided. A voyage was just the thing to cure tuberculosis, but there were degrees of goodness that could be done. For instance a lake cruise was all very well, but a voyage on the bounding salt seas was a surefire cure.

Doctor Kovacic uncovered an old cure for sore throats: goose greese on a warm stocking wrapped around the neck. A red string around the neck would relieve nose bleed. Fruit should be eaten only during the early hours of the day before the stomach was loaded.

Epidemics played a devastatingly large role in Sheboygan county's early medical history. A smallpox epidemic ravaged Sheboygan Falls in 1846, Doctor Kovacic found out. Because of its severity, the local preacher cancelled winter services for his congregation, urging the members to work among the sick instead. In spring, when services were resumed, the preacher discovered that half of his congregation had died from the disease.

In 1850 cholera struck the area, spreading rapidly because of lack of sanitation. Only two doctors, Franke and Alberti, were serving the community at the time. The latter departed for the West, leaving the lone Doctor Frank to aid the stricken region. In a single three-day period he lost his wife, baby and brother-in-law to cholera. Within two years he had died from the same disease.

Doctor Kovacic, in his historical research, found no evidence of prevention for such diseases as cholera and smallpox in those days. For active cases there was a two-story isolation "pest house". A red flag raised above the building denoted scarlet fever patients within; a yellow flag warned of smallpox. For those patients who stayed home, a red lantern flashed the warning, and a policeman kept visitors away from the house.

Doctor Kovacic discovered that over 500 physicians have practiced in Sheboygan county over the years. He singled out a Dr. John Junius Brown as perhaps the most colorful of them all. A stern man, he thundered out against baseball on Sunday, picnics on the same day, and alcohol on any day. He was a chemistry teacher and druggist as well as a doctor. During the Civil War he flew a flag from his drugstore to inform residents of the progress of the fighting. The flag was high and proud if the Union was winning; at half mast if the South was ahead.

Doctor Kovacic discovered that most physicians had drugstores in the early days.

Speaking of physicians and drugstores, it was a physician who probably established the first soda fountain in Wisconsin. The late Fred L. Holmes in *Side Roads* credits Dr. Edward Johnson for performing the delightful deed in his Watertown drugstore. Doctor Johnson had seen a soda fountain in operation in the East but lacked the funds to purchase the device. Finally in 1841 he fashioned one of his own and manufactured it. According to his diary, the fountain was designed of tin, with the pressure coming from a set of connections to the second floor of the store. The tartaric drink didn't immediately satisfy local taste, but gradually it caught on and became popular. Yet, Holmes reports, some time passed before the modern soda fountain was installed in drugstores generally.

THE MEDICAL FORUM

STATE AFFAIRS

SOCIETY SCENE

Council Meeting

As the calendar turned from February into March, SMS Councilors from around the state journeyed to Madison for their key meeting of the year.

In the long Saturday and Sunday deliberations that followed the Council took action on several important matters. Major decisions:
¶ Directed that a letter be sent to chiefs of medical staffs of all Wisconsin hospitals concerning the responsibility of medical management following the administration of pitocin during the course of labor, prior to delivery.

Said the letter in part: "It would be desirable to have all the medical staffs of hospitals include in their hospital regulations the matter of administration of oxytocics and the required supervision of the attending physician until delivery has been completed."
¶ On adoption procedures: (1) recommended adoption agencies use a Council-suggested form for family physicians to fill out for applicants as evidence of certain basic tests that are required; (2) recommended agencies employ "medical consultants" to assume the responsibility of receiving medical reports on infertility and make proper recommendations to the agency in confidence.
¶ Authorized for the first time the awarding of a presidential citation to non-medical persons for outstanding contribution to public health.
¶ Approved a 1959 SMS operating budget with income estimated at $362,150 and expenditures estimated at $351,525.
¶ Passed a resolution honoring Dexter H. Witte, M. D., of Milwaukee, long-time (since 1950) Wisconsin Delegate to the AMA House of Delegates, who is retiring. In part, the resolution read:

"He has been instrumental in guiding determinations of economic, scientific and social significance so as to forward the high purposes and ethics of medicine on national, state and county levels; his service has been such as to command the admiration and emulation of those physicians who will follow . . ."

¶ Elected Dr. James C. Fox., La Crosse, as chairman of the Council to succeed Dr. R. G. Arveson, Frederic, who has served in the post since 1948.

Four other officers were reelected: Dr. F. L. Weston, Madison, treasurer, Drs. H. Kent Tenney and N. A. Hill, both of Madison, assistant treasurers, and C. H. Crownhart, Madison, secretary.

Dr. D. N. Goldstein, Kenosha, was named editorial director of the Wisconsin Medical Journal.

Council Meeting, February 28–March 1, 1959. (l. to r.) Drs. A. H. Heidner, West Bend; L. H. Kilkenny, Milwaukee; J. P. Lokvam, Kenosha; J. H. Conway, Milwaukee; J. H. Houghton, Wisconsin Dells; F. L. Weston, Madison (seated behind table); J. C. Fox, La Crosse (new chairman); E. M. Bell, Marinette; E. M. Dessloch, Prairie du Chien; secretary C. H. Crownhart; Drs. W. B. Hildebrand, Menasha (president); R. G. Arveson, Frederic (retiring chairman); L. O. Simenstad, Osceloa; V. E. Ekblad, Superior; E. L. Bernhart, Milwaukee; P. B. Blanchard, Cedarburg; A. A. Quisling, Madison (seated behind table); W. D. James, Oconomowoc; J. C. Griffith, Milwaukee; H. J. Kief, Fond du Lac; J. D. Leahy, Park Falls; H. E. Kasten, Beloit.

New Chairman of the Council

Dr. James C. Fox of La Crosse, who has been elected as the new chairman of the SMS Council, is well-conditioned for the job. It was 12 years ago, in 1947, when he was chosen by the 7th District to sit on the Council and he has served that governing body continuously ever since. From 1951 to 1954 he was a member of the Council's Interim Committee.

Dr. Fox specializes in internal medicine. In La Crosse's St. Francis Hospital he heads the department of medicine and instructs the hospital's school of nursing. He is medical director of the local St. Michael's Orphanage.

Born in 1906, Dr. Fox attended Loras College in Dubuque and Marquette University. He received his M. D. from Loyola in 1932. His internship and residency were completed at Mercy Hospital in Chicago.

Dr. Fox performed postgraduate work in internal medicine at Massachusetts General Hospital, Peter Bent Brigham Hospital and the Lahey Clinic, Boston.

Council leadership changes as Dr. R. G. Arveson, Frederic, who has held the post of chairman for 11 years, is succeeded by Dr. James C. Fox (right) of La Crosse.

Councilor Caucuses

April 7: First District: Towne Hotel, Oconomowoc: 7:30 p. m.
April 7: Sixth District: Valley Inn, Neenah: 7:30 p. m.
April 8: Second District: Elks Club, Kenosha: 7:30 p. m.
April 9: Fourth District: Dodge Point Country Club, Mineral Point: 7:30 p. m.
April 9: Fifth District: Hotel Foeste, Sheboygan: 7:30 p. m.
April 12: Third District: SMS headquarters, Madison: 3:00 p. m.
April 14: Seventh District: Home of Dr. James Fox, 1131 Cedar Rd., La Crosse: 7:30 p. m.
April 16: Ninth District: Hotel Whiting: Stevens Point: 7:30 p. m.
April 16: Tenth District: Land O'Lakes Hotel, Rice Lake: 7:30 p. m.
April 19: Twelfth District: Headquarters of Med. Soc. of Milw. Co.: 3:00 p. m. (tentative)
April 21: Section Delegates: SMS headquarters, Madison: 7:30 p. m.
April 21: Eleventh District: Hotel Androy, Superior: 7:30 p. m.
April 22: Thirteenth District: Hotel Fenlon, Rhinelander: 7:30 p.m.
April 22: Eighth District: Country Club, Oconto: 7:30 p. m.

PATIENT CARE

Staph Meeting

At the February meeting (postponed from January because of the usual snow storm) of the Wisconsin Commission for the Improvement of Patient Care, held in Milwaukee, the center of attention focused on a roundtable discussion of staphylococcal disease.

Principal speakers were Miss Helen Callon, R. N., Wisconsin State Board of Health; Harold M. Coon, M. D., Director of Milwaukee County General Hospital; and Kenneth J. Winters, M. D., Milwaukee pediatrician.

The following points were developed in the two-hour discussion:

1. Staphylococcal disease must be checked at all costs.
2. Partly because of lack of statistics, too little is currently known about how widespread staphylococcal disease may be in the state.
3. The disease often goes unrecognized because of lack of knowledge, lack of prevention, lack of adequate laboratory equipment and funds.
4. Good housekeeping procedures are the best defense.
5. A Wisconsin-wide campaign should be launched against staph; a campaign of education and of action.
6. The Commission may well be the logical organization to lead such a campaign.

A motion was passed to assess each member organization of the Commission $100 as an initial contribution to finance a state-wide campaign against "all general infection", beginning with staphylococcal disease.

At the business meeting the following were elected: Edward J. Logan, Milwaukee Children's Hospital, Chairman; J. S. Devitt, M. D., Milwaukee, Vice Chairman; Miss Mary Clare Hogan, Milwaukee, Wisconsin League for Nursing, Secretary.

MEDICARE

Late Report

Certain medical benefits for dependents of men in military service have been handled since December, 1956, by the U. S. government's Medicare program. The program allows dependents to elect civilian care even when military facilities are nearby and available.

In Wisconsin, the State Medical Society directs Medicare, acting as an agent for both physicians and the federal government. Under this arrangement neither patient nor physician is pressed with major claims problems.

In a recent report of its first 19 months in operation (Dec., 1956 through Sept., 1958) Medicare detailed payments made in various states:

Indiana	$282,528
Iowa	402,440
Wisconsin	574,194
Minnesota	604,493

MEDICAL TECHNOLOGY

State College Reports

A recent *March of Medicine* broadcast on the opportunities and shortages in the field of medical technology brought forth an encouraging letter from the Wisconsin State College at Stevens Point.

Wrote R. E. Gotham, director of teacher education and placement: "I thought you would be interested in learning that we have . . . a major in this field . . . 36 students who have selected this major."

"Our major," he continued, "provides for three years of academic study on the campus and the fourth year in the local hospital or in the hospital at Marshfield or Wausau."

The program offered at the college, Gotham stated, has been carefully planned to meet the latest of Clinical Pathologists. At the end of the four year course students gain a BS degree and are eligible for registry.

SHEBOYGAN COUNTY

Health Survey

A general health survey of all adults in Sheboygan county has been under way for the past couple of weeks.

A project of the county public health nurses and the State Board of Health, the aim of the survey is to check all men and women over 18 for readily detectable tuberculosis, lung cancer and heart disease.

The last such area survey was held in 1956. At that time a total of 5,538 people were x-rayed in the county. Results showed 5,061 to be essentially negative with no trace of chest diseases. But 411 were referred by the State Board of Health to their family physicians for further evaluation.

DR. W. B. HILDEBRAND
To cut traffic accidents . . .

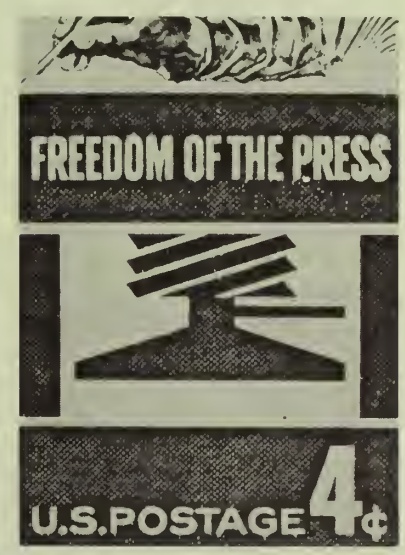
DOUGLAS COUNTY

Fee Schedules

The Douglas County Medical Society has been informed by the welfare departments of the city of Superior and Douglas county that surgical fees for relief recipients would be identical to those provided by the Wisconsin Physicians Service Blue Shield "B" plan.

Assistants' fees in surgery will be continued at $15.00.

Other changes announced by the Douglas County Medical Society and approved by the city-county welfare departments include:



SAMPLE COMMEMORATIVE STAMP
. . . stamp caution into conscience.

Office calls, $3.00; initial office calls, $5.00; hospital calls, (1st through 21 days) $3.00 per day; after 21st day $1.00 per day; house calls, $5.00; night house calls, (7:00 p. m. to 7:00 a. m.) $10.00.

Laboratory fees are similar to those charged by the local hospitals. Example: blood sugar, $3.00; sedimentation rate, $3.00; urinalysis, $1.50; complete blood count, $5.00; electrocardiogram, $12.50.

SOCIETY SCENE

Safety Campaign

A postage stamp campaign to cut traffic accidents was launched by Council of the State Medical Society at its March meeting.

The Society sent a petition to the Postmaster General of the United States to issue an annual commemorative postage stamp on the theme of traffic safety.

The stamps would be issued for five consecutive years with each stamp receiving its first day of issue from the capital cities of every state.

The petition points out that traffic accidents each year kill more than 35,000, injure another 1,400,000 and cause more than $5 billion in lost wages, property damage and medical services.

Dr. William B. Hildebrand, State Medical Society president, and Dr. R. G. Arveson, chairman of the Council, issued a joint statement:

"Every 14 minutes some person dies as a result of a traffic accident. The key to control of this tragic waste of life and limb is the driver."

" We believe that widespread use of a special traffic safety stamp will have the effect of stamping caution into the conscience of millions of Americans who travel our nation's highways."

Drs. Hildebrand and Arveson then pointed out that commemorative stamps have been issued to draw attention to concepts as freedom of the press (see cut) and wildlife conservation.

Duplicate originals of the resolution are being sent to the President of the United States, Wisconsin Congressmen, Governor Nelson and American Medical Association officials.

In addition, the Society is appealing to nation-wide health and safety groups for support in the creation of the commemorative stamp.

P. Carr

R. Bice

W. Clark

W. Moser

C. Lauri

I. Coggs

LEGISLATURE

Two powerful standing committees on public welfare are handling legislative bills that are of vital interest to the medical profession during the current session of the Wisconsin Legislature. Below are brief sketches of these house committee members:

Senate Committee on Public Welfare:

Carr, Peter P. (Chairman); 15th

M. Larsen

L. Merz

district; Rep.; age 68; married, retired; attended Chicago Business College; 524 N. Garfield Ave., Janesville.

Bice, Raymond C.; 32nd district; Rep.; age 62; married; retail lumber dealer; attended U. of Wis. Extension; World War I veteran; 2406 State St., La Crosse.

Clark, William W.; 24th district; Rep.; age 73; married; farmer and cattle buyer; attended Eau Claire State College and U. of Wis.; Route 1, Vesper.

Moser, William R.; 6th district; Dem.; age 31; married; attorney; LL.B. Marquette U. 1953; World War II veteran; 710 N. Plankinton Ave., Milwaukee.

Lauri, Carl E.; 25th district; Dem.; age 34; married; insurance agent; B. S. Superior State College 1954; World War II veteran; 2710 N. 22nd St., Superior.

Assembly Committee on Public Welfare:

Coggs, Isaac N. (Chairman); Milwaukee Co. 6th; Dem.; age 38; married; accountant and tavern-keeper; B. S. U. of Wis. 1948; World War II veteran; 928 W. Meinecke Ave., Milwaukee.

Larsen, Marty (Vice Chairman); Milwaukee Co. 13th; Dem; age 53; married; building manager; B. E. Milwaukee State Teachers College 1936; World War II veteran; 937 W. Center St., Milwaukee.

Merz, Louis L.; Milwaukee Co. 1st; Dem.; age 50; married; owns building supply business, real estate and sales broker, sales representative; attended U. of Wis.-Milw.; served in naval reserve; 5373 N. 13th St., Milwaukee.

Schaeffer, Frank E., Jr.; Milwaukee Co. 4th, Dem; age 53; married; stock room clerk; 1623 W. Wisconsin Ave., Milwaukee.

Vogel, Hugo; Manitowoc Co. 1st; Dem.; age 70; married; retired barber; 1409 S. 12th St., Manitowoc.

Mireau, George; Barron Co.; Dem.; age 70; married; farmer; Route 1, Rice Lake.

Barabe, Robert F.; Ashland and Bayfield Counties; Dem.; age 41; married; merchant; World War II veteran; Mellen.

Blanchard, David J., Rock Co. 2nd; Rep.; age 37; married; attorney; LL.B. U. of Wis. 1943; 11 N. Main St., Edgerton.

Hutnik, Willis J.; Rusk, Sawyer and Washburn Counties; Rep.; age

F. Schaeffer

H. Vogel

43; married; school and office sales; attended Stevens Point State College, U. of Wis.; Tony.

Baumgart, Lloyd; Oconto Co.; Rep.; age 50; married; president carrier mfg. co., hardware store owner, auctioneer, master plumber; Lena.

Shurbert, Floyd E.; Winnebago Co. 2nd; Rep.; age 58; married; retired wholesale and retail meat dealer, mink farmer; attended Oshkosh Business College; Route 4, Box 588, Oshkosh.

G. Mireau

R. Barabe

D. Blanchard

W. Hutnik

L. Baumgart

F. Shurbert

CHIROPRACTIC

Halfway House

Halfway through the month of February came the legislative hearing by the Assembly Public Welfare Committee on a bill that might push chiropractic halfway into the House of Medicine.

Bill 133, A, introduced by Assemblyman Howard F. Pellant (Dem., Milwaukee), would compel all employers to provide, under Workman's Compensation, treatment by chiropractors "upon the demand of the employee". A similar bill had passed the Assembly in 1957.

Author Pellant, who testified that he himself had been aided by chiropractic, stated his case for the bill: "We realize how medicine has its proper place and has done very well with the people of the world. We also understand you cannot cure everything with a pill or a spoonful of medicine."

Before the heavily-attended hearing, Victor Loofboro, president of the Wisconsin Chiropractic Association, said: "Bill 133, A. does nothing more than give the freedom of choice to the employees, that same freedom which he now has guaranteed under the Constitution of Wisconsin."

"Health science". There was further testimony for the bill. That chiropractic was a "health science", that chiropractic-researched statistics on industrial accidents "proved" that chiroprac care was cheaper than medical care (an elaborately-illustrated booklet distributed to the Assembly committee alleged that in 4,476 industrial cases chiropractic care would have proved $259.86 *cheaper per case* than medical-hospitalized care).

Dr. A. Yale Gerol, Monroe, who became a neurological surgeon after 17 years of formal education, led SMS arguments against the bill: "We learned in neurology that there is no such thing as nerve energy, the very foundation of chiropractic . . . The United States Government at the National Institute of Health, and Johns Hopkins have proved time and again, and right in your own University of Wisconsin it has been proved time and time again that it is impossible to realign a vertebra just by pushing on it or moving the legs and so on . . . there can never, never be a loss of nerve energy or decrease in nerve energy because the nerve, like any part, works or not at all."

A representative of the Wisconsin Industrial Commission stated that employers "would not rely upon the reports of chiropractors" in treatment cases, that the present 10% of contested cases before the Commission could well rise to an expensive 25%.

During the rebuttal, an Assembly committee member asked a chiropractor: "What facilities do you use for diagnosis of some type of kidney injury?" Back came the reply: "We have urinalysis laboratories, and so on. We have all that type of thing at our disposal at any time."

Such testimony was particularly revealing since the following speaker from the State Chamber of Commerce quoted from a Supreme Court decision that a chiropractor "has no right to make a medical diagnosis."

DR. A. R. CURRERI
He summed it up.

Dr. J. S. Devitt, president of the Milwaukee Medical Society, pleaded that to pass such a chiropractic bill "would not be in the public good because it would permit and, perhaps, even encourage the treatment of the injured . . . by the unskilled . . ."

Others speaking against the bill included the Wisconsin Manufacturers" Association and the Advisory Committee on Workman's Compensation, representing labor and management. (In addition, 22 others representing organizations registered against the bill but could not testify within the time limits set by the committee.)

Expert medical testimony was continued by Dr. Herman W. Wirka, orthopedic surgeon from the UW Medical School: "I think the problem is one entirely of whether or not the chiropractor has the ability, the wherewithal at his command, instruments at his command, to make a complete evaluation of the employee's illness . . ."

Dr. A. R. Curreri, UW Medical School surgeon, summed it up for the medical profession: "As far as research is concerned, acceptance of this Bill would be tantamount to saying 'we might just as well forego all types of research except that relating to the nerves'."

"Obviously," concluded Dr. Curreri, "All research we are doing in relation to cancer and heart disease and other diseases would be completely stopped."

The eleven-member Assembly Committee on Public Welfare, some days later, recommended that Bill 133, A. become the law of the land, with only one dissenting vote.

Legislative Briefs

With bills coming in at a rapid rate, the interests of medicine and public health are taking on increasing significance in the state legislature.

Bills of specific interest in the state legislature:

¶ 129,A.—Permits the employment of physicians by hospitals and authorizes the corporate practice of medicine and the practice of fee splitting. Sponsored by the Wisconsin Hospital Association. State Medical Society opposed.

¶ 133,A. — Chiropractic under Workmen's Compensation. State Medical Society opposed.

¶ 154,A. — Chiropractic qualifications. Requires chiropractic applicants for license to show evidence of graduation from a chiropractic school which, in the teaching of comparable subjects, is determined by the registrar of the University of Wisconsin to be substantially equivalent in the quality of its faculty, facilities and teaching methods to the University.

¶ 319,A.—New school employees would be permitted to submit results of an examination and chest x-ray taken within two years of application for employment in lieu of a current examination and x-ray. Society Committee on Chest Diseases studying.

¶ 343,A.—Requires that where a court has ordered a personal injury claimant to submit to a physical examination, a full and complete copy of the physician's report shall be furnished to the claimant or his attorney.

¶ 347, A.—Would remove the immunity against tort liability now

enjoyed by charitable, religious or industrial corporations in Wisconsin, but sets $25,000 limit on recovery by one party.

¶ 353,A.—Optometry—defines optometry as a profession devoted to the care and correction of human vision by means other than medicine or surgery, restricts the practice of opticianry and requires public agencies referring cases for visual care to give choice of optometrist and physician.

¶ 423,A.—Psychologists. Creates a licensing board for psychologists but prohibits their treatment of the sick.

On the other side of Capitol Hill, the Senate has a growing number of bills affecting public health.

¶ 1,S.—Mental Health Advisory Board. SMS supports but urges ex-officio status for members representing five state agencies.

¶ 2,S.—Community Mental Health Clinics. SMS supports but favors more detailed study by mental health advisory board created in 1,S. before planning is inaugurated.

¶ 3,S.—Treatment Center for Emotionally Disturbed Children. SMS favors but urges University of Wisconsin Medical School have a voice in applicants and supervision of professional staff.

¶ 79,S.—Permits district school board to employ public health nurses, dentists and physicians but removes such personnel from supervision of local and state boards of health.

¶ 177,S.—Permits physicians holding temporary educational certificates (usually foreign trained residents) to renew certificate four times. Sponsored by State Medical Society.

¶ 178,S.—Permits applicant for medical license to write examination before he serves his internship. License issued upon completion of internship without delay. Sponsored by State Medical Society.

¶ 179,S.—Chiropody certificates—requires chiropodists to record certificate of registration with county clerk and permits board of medical examiners to collect annual renewal fees on behalf of chiropody examining committee. Sponsored by State Medical Society.

¶ 180,S.—Extends to 1963 a present law permitting issuance of temporary licenses to practice medicine in communities where medical emergency exists and between meetings of the board of medical examiners. Sponsored by the State Medical Society.

NATIONAL AFFAIRS

BLUE SHIELD

Portent of the Future

At a mid-February conference on Blue Shield professional relations, held in Chicago, it was Dr. Louis M. Orr, president-elect of the AMA, who sketched his portent of the future.

After drawing a picture of government-controlled medicine in Europe, Mr. Orr swung back to the U. S. and underlined the controversial Forand bill now before Congress.

The next 10 months will tell the story, Dr. Orr warned delegates (including SMS representatives). He stated that new and attractive features will be added to the Forand measure to make it much harder to recognize as detrimental to free medicine.

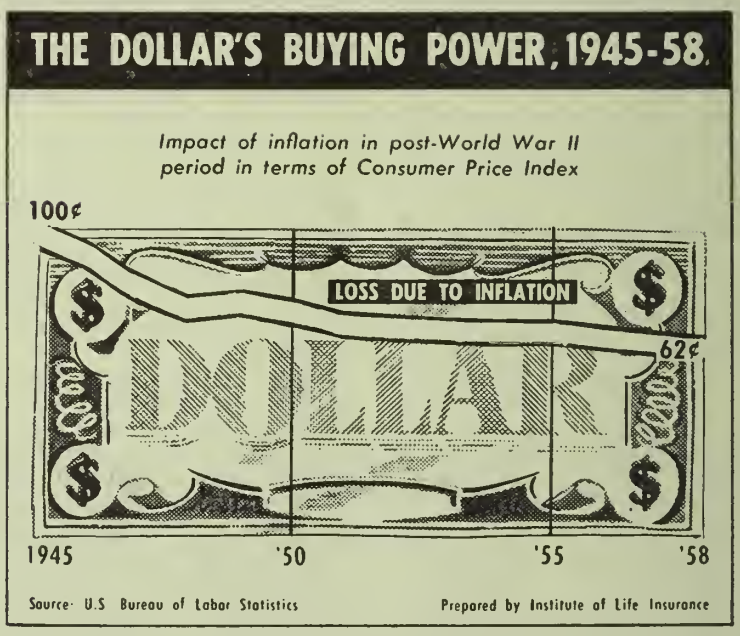
If the bill is passed, Dr. Orr estimated that within ten years the cost of Society Security per individual will rise to a high of $216 annually or almost double what it is now. (Dr. Orr's figures do not take into account that Congress traditionally votes costly new Social Security extensions and benefits in an election year).

Dr. Donald Stubbs, chairman of Blue Shield's board of directors, also commented on the Forand Bill, pointing out that, "Blue Shield plans have been enrolling the aged citizens at a faster rate than any other age group of subscribers in the past five years."

"About 40% of the over-65 population now have Blue Shield insurance," Dr. Stubbs continued. "Only 60% of our total aged citizens now have Social Security."

With the new AMA health plan for the Aged, Dr. Stubbs said that physicians were proving "that we are approaching our responsibility to this age group in a rapid manner." He urged all states to quickly approve of state-wide plans similar to the AMA proposal as further proof to Congress that the problem of health insurance can be solved within the Blue Shield concept.

Members of the conference reported that Kentucky's House of Delegates will vote on an AMA-based health plan shortly, and Iowa is preparing a similar plan. A trial plan is being readied in Wisconsin by Wisconsin Physicians Service.



The old inflation story was revealed by above graph illustrating third round of cheapened purchasing power since end of World War II. Last round, starting early in 1956, had boosted the cost of living by 8% when it hit its peak last July.

EDUCATION

AMA EXHIBIT "7 PATHS TO FITNESS"
Divine or delinquent: the key to the future.

CONFERENCE

Youth Holds the Key

Conscious of the fact that it is the young, whether divine or delinquent, that hold the key to Wisconsin's future, a Sixth Governor's Conference on Children and Youth has been called for April 3–4 at the Wisconsin Center, Madison.

Essentially a state-wide citizen's meeting (and open to the general public) it is designed "for the lay adult, the professional, and the youth of the state to talk and plan together to meet the needs of our children and youth."

The theme of the conference is "Exploring Inner Space", and that inward examination of what makes children tick (and what to do about it) will be handled in 31 guided discussion sections. The sections will cover virtually every subject. Example: Pals or Parents, Employed Mothers, Of Praise or Punishment, Youth and Money, Psychology of Prejudice.

The State Medical Society will participate in the conference, and, mindful that health is a critical phase of development in the young, has arranged for "7 Paths to Fitness" (see cut), the excellent American Medical Association traveling exhibit, to be on view at the Wisconsin Center.

The conference is under the general sponsorship of the Wisconsin Committee on Children and Youth whose chairman is Dr. H. Kent Tenney, Madison.

Registrations are being accepted at the Conference Office, 311 State St., Madison.

MEDICAL COLLEGES

Record Enrollment

American medical colleges had a record enrollment of 29,473 students, including a new high of 8,030 freshmen, in the 1957–1958 school term.

During the past year, 60 of the 85 operating medical schools reported major construction costing $47,000,000 in the planning, beginning or completion stages.

Forty-nine schools reported major developments and changes in administrative organization, methods of student selection, curriculum and financing.

The schools spent $275,000,000 in 1957–1958, an increase of 13 per cent over the preceding 12-month period.

Commenting on the schools, the A. M. A. Council on Medical Education and Hospitals stated:

"The increasing population together with various other facets of the shifting (population) pattern obviously indicate the need for constantly increasing the number of physicians.

"This means that existing medical schools must consider expanding their facilities, and institutions of higher learning without medical education programs need to give serious consideration to the development of medical programs."

The schools graduated 6,861 physicians last June, compared with 6,796 in 1957 and 6,977 in 1955. The total in 1958 included 355 women.

The American Medical Education Foundation raised $984,787 from physicans for medical schools in 1957 and a record $1,133,654 in 1958. The National Fund for Medical Education, which receives its money from industry, contributed $3,078,825 last January.

The council said the median annual cost of medical school to a student in a private institution was $1,958, and in a state-owned school, $1,395 to residents and $1,731 to non-residents. The median amount spent by a four-year school in 1957–1958 was between $2,300,000 and $2,400,000.

SCHOLARSHIPS

Medical–Social Field

Students attending any approved graduate professional school of social work offering a medical social field work placement are eligible for scholarships provided by the National Foundation.

The student must be accepted for admission by a school accredited by the Council on Social Work Education but may file application for a scholarship pending acceptance for admission to the school.

Further information on the scholarship program may be obtained from the dean of any college or university. Deadline for filing applications is April 1, 1959.

FILMS

No Margin for Error

The AMA and AHA have released a new film, *No Margin For Error*, on hospitals and the law.

No Margin For Error is a 30-minute, black and white presentation on a pressing problem in legal medicine: the cause and effect of human mistakes in the complex system of the modern hospitals.

Case histories, such as a mix-up in patient identification, mistakes in blood bank procedure and error in medication dosage, are portrayed. The film reports that 45% of all medication errors occur as a result of mistakes in patient identification.

No Margin For Error, produced by the Wm. S. Merrell Co., pharmaceutical manufacturers, is on 16mm. sound film.

Loan copies are available from the AMA.

Doctors' efforts to push polio shots in their own communities will get a big boost from Metropolitan Life Insurance Co. when above advertisement appears on April 1 in national magazines with circulations totalling 36 million people.

PSS
PROFESSIONAL BUSINESS SERVICE
1204 State Street
La Crosse, Wisconsin

Business Consultants to the Medical Profession.

Inquiries Invited

MISCELLANY

QUACKERY

Bottoms Up

Foot massagers in South Dakota are calling themselves by the impressive title of "Reflexologist". And, according to the California Medical Association, the cultists are charging plenty for working from the bottom up.

Nature Boy

A public nuisance: so said Missouri's Supreme Court in handing down an order for a naturopath to close his Kansas City clinic; permanently.

INCOME PROTECTION INSURANCE

provides a tax-free income

when you need it most . . when you are unable to perform duties of your profession.

TIME HEALTH POLICIES

guarantee up-to-date protection specifically designed to meet your special needs

T·I·C

TIME INSURANCE COMPANY
MILWAUKEE
WISCONSIN

"New Impressions in Medicine"

118th ANNUAL MEETING

of the State Medical Society of Wisconsin

MAY 5-6-7, 1959

Hotel Schroeder
and
Milwaukee Auditorium
MILWAUKEE, WISCONSIN

COMPLETE PROGRAM ON FOLLOWING PAGES

1959 ANNUAL MEETING

TIMETABLE

MONDAY, MAY 4

a.m.—Golf tournament at North Hills Country Club
5:00 p.m.—New Delegates and Alternates meeting at Hotel Schroeder
7:30 p.m.—House of Delegates at Hotel Schroeder

TUESDAY, MAY 5

General Practice Day

8:00 a.m.—Registration at Auditorium
Exhibits open at Auditorium
9:00 a.m.—General session at Auditorium
9:00 a.m.—Reference Committees, House of Delegates, at Hotel Schroeder
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Alumni luncheons at Auditorium
2:00 p.m.—General session at Auditorium
6:00 p.m.—Buffet for Delegates and Alternates at Hotel Schroeder
7:30 p.m.—House of Delegates at Hotel Schroeder
8:00 p.m.—Fireside conferences at Hotel Schroeder

WEDNESDAY, MAY 6

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—House of Delegates at Hotel Schroeder
9:00 a.m.—General session at Auditorium
9:00 a.m.—Special program on internal medicine at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Luncheon for officers and members of SMS Charitable, Educational and Scientific Foundation at Hotel Schroeder
12:15 p.m.—Luncheon for Wisconsin Clinic Managers Association at Hotel Schroeder
2:00 p.m.—Special programs on internal medicine, obstetrics and gynecology, psychiatry, pediatrics, orthopedic and plastic surgery at auditorium
6:15 p.m.—President's reception
7:15 p.m.—Annual dinner

THURSDAY, MAY 7

8:00 a.m.—Registration at Auditorium
8:30 a.m.—Special breakfast conference and wet clinic on dermatology at Auditorium
9:00 a.m.—Exhibits open at Auditorium
11:00 a.m.—General session at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Past president's luncheon
2:00 p.m.—Special programs on anesthesia, dermatology, radiology, and surgery at Auditorium; ophthalmology and otolaryngology at Hotel Schroeder

1959 PROGRAM

The scientific programs for this year's annual meeting have been prepared under the direction of Melvin F. Huth, M.D., Baraboo, in cooperation with the Council on Scientific Work of SMS and representatives of the several sections of SMS and specialty organizations in Wisconsin.

MELVIN F. HUTH, M.D.
General Program Chairman

COUNCIL ON SCIENTIFIC WORK

Kenneth E. Lemmer, M.D. ..... Madison
Chairman

Melvin F. Huth, M.D. ..... Baraboo
Program Chairman

Roy B. Larsen, M.D. ..... Milwaukee
Chairman, Scientific Exhibits

M. C. F. Lindert, M.D. ..... Milwaukee
Chairman, Roundtable Luncheons

R. W. Farnsworth, M.D. ..... Janesville

John Z. Bowers, M.D. ..... Madison
Dean, University of Wisconsin Medical School

J. S. Hirschboeck, M.D. ..... Milwaukee
Dean, Marquette University School of Medicine

R. S. Baldwin, M.D. ..... Marshfield
Medical Editor, *The Wisconsin Medical Journal*

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Streets. The time: Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday and Thursday, 8:00 a.m.–4:00 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Medical students, medical assistants and hospital personnel will be admitted on Thursday (after 12 noon). Interns and residents admitted without registration fee, if certified by hospital. Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies admitted by membership cards.

★ **VA AND M.D.'s IN MILITARY SERVICE:** Members of the Veterans Administration must be members of the State Medical Society to be admitted. Physicians in the armed services admitted by presenting certification of current military status.

GENERAL PRACTICE DAY

Tuesday, May 5

(6 Hours Category 1 Credit)

MORNING SESSION

PLANKINTON HALL, AUDITORIUM

Moderator: David Goldstein, M.D., Kenosho

9:00 a.m.—NEWER CONCEPTS IN THE TREATMENT OF DUODENAL ULCER

Moderator: **M. C. F. Lindert, M.D.,** Milwaukee

MEDICAL CONSIDERATIONS: **C. Joseph DeLor, M.D.,** Columbus, Ohio

SURGICAL CONSIDERATIONS: **E. H. Ellison, M.D.,** Milwaukee

10:15 a.m.—Recess

11:00 a.m.—NEWER DEVELOPMENTS IN VASCULAR SURGERY

John T. Phelan, M.D., Madison

11:30 a.m.—AN EVALUATION OF RADIATION THERAPY IN THE TREATMENT OF CANCER

R. Kenneth Loeffler, M.D., Madison

AFTERNOON SESSION

PLANKINTON HALL, AUDITORIUM

Moderator: Charles Picard, M.D., Superior

2:00 p.m.—SOME PITFALLS IN THE DIAGNOSIS OF CONGENITAL HEART DISEASE

James W. DuShane, M.D., Rochester, Minn.

(Lecture sponsored by Wisconsin Heart Association)

2:30 p.m.—A STUDY OF POST-PELVIC SURGERY PATIENTS ADMITTED TO A PSYCHIATRIC HOSPITAL

Marc Hollender, M.D., Syracuse, N.Y.

(Rogers Memorial Lecture, Rogers Memorial Hospital, Oconomowoc)

3:00 p.m.—Recess

3:30 p.m.—PROLONGED LABOR

Moderator: **T. A. Leonard, M.D.,** Madison

Participants: **F. J. Hofmeister, M.D.,** Milwaukee; **G. S. Kilkenny, M.D.,** Milwaukee; **R. J. Sanderson, M.D.,** Beloit

GENERAL SESSIONS

Wednesday, May 6

PLANKINTON HALL, AUDITORIUM

9:00 a.m.—AMPUTATIONS AND PROSTHESIS (Wet Clinic)

Coordinator: **Walter Stenborg, M.D.,** Milwaukee County Hospital

ORTHOPEDIC INDICATIONS FOR AMPUTATION

James R. Regan, M.D., Milwaukee

VASCULAR CONSIDERATIONS IN AMPUTATIONS

Henry Twelmeyer, M.D., Milwaukee

TECHNIQUE OF AMPUTATION, STUMP CARE, AND PROSTHESIS FITTING AND TRAINING

Thomas J. Canty, M.D., Oakland, Calif.

ROLE OF THE PHYSIATRIST IN AMPUTATIONS, AND REHABILITATION FACILITIES AVAILABLE IN WISCONSIN

Edwin Welsh, M.D., Milwaukee

(Patients furnished by VA Hospital, Wood and Milwaukee County Hospital)

10:15 a.m.—Recess

Moderator: M. F. Huth, M.D., General Program Chairman

11:00 a.m.—DIAGNOSTIC AND THERAPEUTIC APPLICATIONS OF RADIOISOTOPES IN MEDICINE

Oscar B. Hunter, Jr., M.D., Washington, D.C.

11:30 a.m.—CLASSIFICATION OF FORCEPS OPERATIONS ACCORDING TO STATION OF HEAD IN PELVIS

Edward H. Dennen, M.D., New York City

Thursday, May 7

JUNEAU HALL, AUDITORIUM

8:30 a.m.—SPECIAL BREAKFAST CONFERENCE AND WET CLINIC ON DERMATOLOGY

(Planned in cooperation with the Wisconsin Dermatological Society)

Moderator: **Daniel E. Hackbarth, M.D.,** Milwaukee

Discussant: **Earl D. Osborne, M.D.,** Buffalo, N.Y.

Free coffee and sweet rolls! Physicians are invited to attend at 8:30 sharp so that full benefit of the teaching program can be enjoyed. Cases will be presented by Milwaukee dermatologists.

10:15 a.m.—Recess

GENERAL SESSION

PLANKINTON HALL, AUDITORIUM

Moderator: M. C. F. Lindert, M.D., Milwaukee

11:00 a.m.—THE INTERPRETATION OF ESOPHAGEAL SYMPTOMATOLOGY

Franz J. Ingelfinger, M.D., Boston, Mass.

(William Beaumont Memorial Lecture)

11:30 a.m.—PRESENT STATUS OF ORAL AGENTS IN THE TREATMENT OF DIABETES

William Engstrom, M.D., Milwaukee

SPECIALTY PROGRAMS

(All programs open to entire membership, though planned by groups noted)

Wednesday, May 6

SPECIAL PROGRAM ON INTERNAL MEDICINE

PLANKINTON HALL, AUDITORIUM

(Arranged in cooperation with Wisconsin Society of Internal Medicine)

Moderator: Maurice Hardgrove, M.D., Milwaukee

9:00 a.m.—GASTROINTESTINAL MANIFESTATIONS OF POLYARTERITIS NODOSA
Valerio Turgai, M.D., Milwaukee

9:20 a.m.—THE USE OF THE MECHANICAL KIDNEY FOR DIALYSIS IN TWINS, PRIOR TO RENAL TRANSPLANT
Douglas J. Coy, M.D., Milwaukee

9:40 a.m.—THE EFFECT OF STEROID THERAPY ON ELECTROLYTE EXCRETION PATTERNS
F. Gilbert McMahon, M.D., Madison

10:00 a.m.—THE INFLUENCE OF LUNG VOLUME ON PULMONARY DIFFUSING CAPACITY AND CAPILLARY BED
John H. Ramlo, Medical Student, Madison

10:15 a.m.—Recess

Moderator: Paul G. LaBissoniere, M.D., Milwaukee

11:00 a.m.—SERUM ENZYMES IN THE STUDY OF TISSUE INJURY (Especially in Reference to Hepatotoxic Effects from Drugs)
John F. Morrissey, M.D., Madison

11:30 a.m —EFFECT OF POTASSIUM ON SMALL AND LARGE VESSELS
Dean Emanuel, M.D., Marshfield

INTERNAL MEDICINE

PLANKINTON HALL, AUDITORIUM

(Planned in cooperation with Wisconsin Society of Internal Medicine)

Moderator: Karl Doege, M.D., Marshfield

2:00 p.m.—UNUSUAL MALABSORPTION SYNDROMES
J. D. Kabler, M.D., Madison

2:30 p.m.—MECHANISMS AND MANAGEMENT OF ASCITIES
James C. Cain, M.D., Rochester, Minn.

3:00 p.m.—Recess

Moderator: Robin N. Allin, M.D., Madison

3:30 p.m.—LONG-TERM RESULTS OF MITRAL AND AORTIC VALVULAR SURGERY
Richard Botham, M.D., Madison

4:00 p.m.—RADIOLOGIC ASPECTS OF DYSPHAGIA INVOLVING THE LOWER ESOPHAGUS
Robert G. Zach, M.D., Monroe

OBSTETRICS AND GYNECOLOGY

JUNEAU HALL, AUDITORIUM

(Planned in cooperation with Wisconsin Society of Obstetrics and Gynecology)

Moderator: William Luetke, M.D., Madison

2:00 p.m.—THE EVOLUTIONARY SIGNIFICANCE OF UREA EXCRETION IN MAN
Alfred L. Kennan, M.D., Madison

2:30 p.m.—INDICATIONS FOR AND SELECTION OF FORCEPS FOR OBSTETRICAL DELIVERIES
Edward H. Dennen, M.D., New York City

3:00 p.m.—Recess

3:30 p.m.—FUNCTIONAL OVARIAN TUMORS
Ronald R. Greene, M.D., Chicago, Ill

4:00 p.m.—THE VALUE OF TRANSVAGINAL PUDENDAL BLOCK IN OBSTETRICAL ANESTHESIA
John J. Brennan, M.D., Milwaukee

PSYCHIATRY

KILBOURN HALL, AUDITORIUM

(Planned in cooperation with Milwaukee Neuro-Psychiatric Society and the Wisconsin Psychiatric Society)

Moderator: Edward C. Schmidt, M.D., Milwaukee

2:00 p.m.—MARRIAGE AND DIVORCE
Marc Hollender, M.D., Syracuse, N.Y.
(Rogers Memorial Lecture, Rogers Memorial Hospital, Oconomowoc)

3:00 p.m.—Recess

3:30 p.m.—EARLY DETECTION AND TREATMENT OF SCHIZOPHRENIA

Moderator: E. C. Schmidt, M.D., Milwaukee

Discussant: **Marc Hollender, M.D.,** Syracuse, N.Y.

Participants: **Edward Burns, M.D.,** Madison; **William Studley, M.D.,** Milwaukee; **Samuel Black, M.D.,** Milwaukee; **Mr. Frank Brennan,** Milwaukee

PEDIATRICS

WALKER HALL, AUDITORIUM

(Planned in cooperation with the Wisconsin Chapter of the American Academy of Pediatrics)

Moderator: James P. Conway, M.D., Milwaukee

2:00 p.m.—THE ADOLESCENT: THE NEGLECTED AREA IN PEDIATRICS
Sherman Little, M.D., Los Angeles, Calif.

(continued)

SPECIALTY PROGRAMS

WEDNESDAY • PEDIATRICS (continued)

2:30 p.m.—PARA-NATAL MORTALITY
Heyworth N. Sanford, M.D., Chicago, Ill.

3:00 p.m.—Recess

3:30 p.m.—PRACTICAL PEDIATRIC FLUID THERAPY
Gerald Kerrigan, M.D., Milwaukee

4:00 p.m.—SELECTION OF PATIENTS WITH VENTRICULAR SEPTAL DEFECT FOR SURGICAL TREATMENT
James W. DuShane, M.D., Rochester, Minn.
(Sponsored by Wisconsin Heart Association)

ORTHOPEDIC AND PLASTIC SURGERY

ENGELMANN HALL, AUDITORIUM
(Planned in cooperation with the Wisconsin Society of Orthopedic Surgery)
Moderator: James W. Nellen, M.D., Green Bay

2:00 p.m.—AMPUTATION SURGERY AND MODERN PLASTIC LIMBS
Capt. Thomas J. Canty, MC, USN, Oakland, Calif

2:30 p.m.—PROSTHESIS OF THE HIP
Frederick Gaenslen, M.D., Milwaukee

3:00 p.m.—Recess

3:30 p.m.—RECONSTRUCTIVE SURGERY OF THE HAND
John L. Bell, M.D., Chicago, Ill.

4:00 p.m.—MANAGEMENT OF CONTRACTURES ASSOCIATED WITH BURN SCARS
John C. Kelleher, M.D., Toledo, Ohio

BEFORE LEAVING FOR MEETING

GIVE YOUR SECRETARY THIS INFORMATION

TELEPHONE SERVICE: Registration Desk, Milwaukee Auditorium—BR. 1-9609. For Milwaukee MDs, Direct call through BR 1-4131 and it will be relayed to a special phone near the main meeting hall at the Auditorium. For Those at Luncheons: 5th Floor Foyer phone at Hotel Schroeder—BR 1-7250. Tell your secretary the room number of the luncheon, so we can locate you!

HOSTS FOR GUEST SPEAKERS

SPEAKER	HOST
JOHN L. BELL, M.D.	WILLIAM FRACKELTON, M.D.
CLIFFORD D. BENSON, M.D.	KENNETH LEMMER, M.D.
JAMES CAIN, M.D.	J. L. SIMS, M.D.
JOHN A. CAMPBELL, M.D.	DONALD BABBITT, M.D.
THOMAS J. CANTY, MC, USN	E. L. BERNHART, M.D.
ANTHONY C. CIPOLLARO, M.D.	M. J. REUTER, M.D.
JOSEPH DE LOR, M.D.	E. H. ELLISON, M.D.
EDWARD H. DENNEN, M.D.	ROLAND CRON, M.D.
KENNETH DEVINE, M.D.	L. G. EBY, M.D.
JAMES DU SHANE, M.D.	L. R. SCHWEIGER, M.D.
RONALD R. GREENE, M.D.	F. J. HOFMEISTER, M.D.
S. G. HERSHEY, M.D.	W. S. PHILLIPS, M.D.
FRED J. HODGES, M.D.	R. W. BYRNE, M.D.
MARC HOLLENDER, M.D.	BERNHARD KAUFMAN, M.D.
OSCAR B. HUNTER, M.D.	D. J. CARLSON, M.D.
FRANZ INGELFINGER, M.D.	M. C. F. LINDERT, M.D.
JOHN C. KELLEHER, M.D.	PAUL NATVIG, M.D.
SHERMAN LITTLE, M.D.	JOHN PETERSON, M.D.
JOHN M. McLEAN, M.D.	DONALD T. HUGHSON, M.D.
EARL D. OSBORNE, M.D.	HARRY FOERSTER, SR., M.D.
HEYWORTH N. SANFORD, M.D.	H. KENT TENNEY, M.D.
WYNNE SHARPLES, M.D.	VIRGINIA DOWNES, M.D.
V. K. STOELTING, M.D.	J. W. BOOKHAMER, M.D.

STATE MEDICAL GOLF TOURNAMENT

North Hills Country Club

MONDAY, MAY 4, 1959

The annual spring tournament of the Wisconsin State Medical Golf Association will be held Monday, May 4, 1959, at the North Hills Country Club, Milwaukee. Reservations may be made by writing to A. H. Luthmers, Executive Secretary, Wisconsin State Medical Golf Association, 756 North Milwaukee Street, Milwaukee 2, Wisconsin.

Tournament activity will include, golf, dinner, entertainment, a blind bogey event and the awarding of prizes. Trophies will be given for first low gross score, senior low gross, first low net and second low net. There will also be prizes for the longest drives on two tees and the closest to the pins on two greens.

SPECIALTY PROGRAMS

(All programs open to entire membership, though planned by groups noted)

Thursday, May 7

ANESTHESIA

KILBOURN HALL, AUDITORIUM

(Planned in cooperation with Wisconsin Society of Anesthesiologists)

Moderator: James W. Bookhamer, M.D., Milwaukee

2:00 p.m.—METHOHEXITAL: A NEW INTRAVENOUS BARBITURATE
V. K. Stoelting, M.D., Indianapolis, Ind.

2:30 p.m.—HALOGENATED HYDROCARBONS
Karl L. Siebecker, M.D., Madison

3:00 p.m.—Recess

3:30 p.m.—EXPERIMENTAL PROTECTION AGAINST SHOCK
Solomon G. Hershey, M.D., New York City

4:00 p.m.—TEMPERATURE CHANGES DURING PEDIATRIC ANESTHESIA
Betty J. Bamforth, M.D., and **Walter M. Kelley, M.D.,** Madison

DERMATOLOGY

JUNEAU HALL, AUDITORIUM

(Planned in cooperation with Wisconsin Dermatological Society)

Moderator: Donald M. Ruch, M.D., Milwaukee

2:00 p.m.—THE DIAGNOSIS AND TREATMENT OF ANO-GENITAL ITCHING
Earl D. Osborne, M.D., Buffalo, N.Y

2:30 p.m.—THE EFFECT OF CHELATING COMPOUNDS ON ACROSCLEROSIS AND SARCOIDOSIS, with Comments on Tryptophan Metabolism in Acrosclerosis
Sture A. M. Johnson, M.D., Madison

3:00 p.m.—Recess

3:30 p.m.—PRESENT TRENDS IN RADIATION THERAPY IN DERMATOLOGY
Anthony C. Cipollaro, M.D., New York City

4:00 p.m.—DERMAL CONTACT DERMATITIS
Stephen Epstein, M.D., Marshfield

OPHTHALMOLOGY AND OTOLARYNGOLOGY

EAST ROOM HOTEL SCHROEDER

(Planned in cooperation with Section on Ophthalmology and Otolaryngology. Scientific program will follow luncheons of Doctors McLean and Devine)

Moderator: Peter Duehr, M.D., Madison

2:00 p.m.—Business meeting

2:30 p.m.—COMPLICATIONS FOLLOWING CATARACT EXTRACTION
John M. McLean, M.D., New York City

3:00 p.m.—POSITON NYSTAGMUS: Its Value in Diagnosis of Lesions in the Vestibular Apparatus, Both Central and Peripheral, and
GLOBUS HYSTERICUS: Diagnosis and Treatment by Electromyography
John K. Scott, M.D., Madison

3:30 p.m.—GONIOSCOPY: A Practical Clinical Aid
Herbert Giller, M.D., Milwaukee

4:00 p.m.—BENIGN TUMORS OF THE NOSE AND THROAT
Kenneth Devine, M.D., Rochester, Minn.

RADIOLOGY

WALKER HALL, AUDITORIUM

(Planned in cooperation with Wisconsin Radiologic Society)

Moderator: S. R. Beatty, M.D., Neenah

2:00 p.m.—EXPERIENCES WITH A NEW ORAL CHOLECYSTOGRAPHIC MEDIUM—ORABILEX
J. P. O'Laco, M.D., Milwaukee

2:15 p.m.—ROENTGEN FINDINGS IN SPLENIC HEMORRHAGE
J. R. Amberg, M.D., Milwaukee

2:30 p.m.—THE X-RAY DETECTION OF PULMONARY CANCER
Fred J. Hodges, M.D., Ann Arbor, Mich.

3:00 p.m.—Recess

3:30 p.m.—RADIOLOGY OF PATENT DUCTUS ATERIOSUS
John A. Campbell, M.D., Indianapolis, Ind.

4:00 p.m.—THE OSTEOPOROSIS OF HYPERCORTISONISM
Willard Howland, M.D., Milwaukee

4:30 p.m.—SOME ROENTGEN MANIFESTATIONS OF INTESTINAL TUBERCULOSIS
W. A. Wilcox, M.D., Milwaukee

(continued)

SPECIALTY PROGRAMS

THURSDAY (continued)

SURGERY

PLANKINTON HALL, AUDITORIUM

(Planned in cooperation with the Wisconsin Surgical Society)

Moderator: Kenneth E. Lemmer, M.D., Madison

2:00 p.m.—THE DIAGNOSIS AND TREATMENT OF CHEST LESIONS SEEN IN EVERYDAY PRACTICE
E. E. Eckstam, M.D., Monroe

2:20 p.m.—BENIGN AND MALIGNANT ABDOMINAL MASSES IN INFANCY AND CHILDHOOD
Clifford D. Benson, M.D., Detroit, Mich.
(Sponsored by Milwaukee and Wisconsin Divisions, American Cancer Society)

2:50 p.m.—THE VALUE OF URINARY AMYLASE DETERMINATIONS IN ACUTE PANCREATITIS
Peter A. Midelfart, M.D., Eau Claire

3:10 p.m.—Intermission

3:30 p.m.—APPENDICITIS IS STILL WITH US
James M. Sullivan, M.D., Milwaukee
(Presidential Address of Wisconsin Surgical Society)

4:00 p.m.—REVIEW OF THE FUNNEL CHEST PROBLEM
Paul F. Hausmann, M.D., Milwaukee

4:20 p.m.—MANAGEMENT OF ARTERIAL INJURIES OF THE LOWER EXTREMITY
James E. Conley, M.D., Milwaukee

W. B. HILDEBRAND, M.D.
President
State Medical Society
of Wisconsin

The 118th Annual Meeting of our Society, set for May 5–6–7, 1959, will be one of the highlights of the year's activities. I urge every Wisconsin physician to attend all, or at least one, of the meetings during the three-day event at Milwaukee. These meetings have been carefully planned for the greatest interest and needs of Wisconsin physicians with the very finest of speakers from all over the States.

HOUSE OF DELEGATES

Meetings of the House of Delegates are regarded as among the most important functions of the Annual Meeting of the State Medical Society. Reports of the officers and committees, as well as new business, will be presented at the initial session of the House at 7:30 p.m., Monday, May 4.

On Tuesday morning at 9:00, the reference committees will meet.

It is a privilege as well as an opportunity for any member of the Society to appear before these committees and present his views on any matter properly before them. Any member, whether he wishes to appear before the committees or merely to listen in on their deliberations, is urged to participate in this extremely important phase of Society activities.

You are also invited to attend the other sessions of the House at 7:30 p.m. Tuesday and 9:00 a.m. Wednesday.

"FIFTY YEAR CLUB"

Eleven fine gentlemen of medicine, in active practice for a half century, will be honored at the Annual Dinner of the State Medical Society on Wednesday evening, May 6.

In recognition of this long, outstanding period of service, the following physicians will be granted certificates and pins as newly qualified members of this exclusive club:

FREDERICK A. DAVIS, M.D.	Madison
GUSTAVE E. ECK, M.D.	Lake Mills
VICTOR E. EKBLAD, M.D.	Superior
HUGH P. GREELEY, M. D.	Madison
GEORGE T. HEGNER, M.D.	Appleton
WILLIAM C. LIEFERT, M.D.	Milwaukee
EDMUND H. MENSING, M.D.	Milwaukee
FRED J. PFEIFER, M.D.	New London
GEORGE A. STEELE, M.D.	Oshkosh
GUY F. WAKEFIELD, M.D.	West Salem
ARTHUR J. WIESENDER, M.D.	Berlin

Roundtable Luncheons

The roundtable luncheons, which have been arranged under the direction of M. C. F. Lindert, M.D., Milwaukee, will be held at the Hotel Schroeder starting at 12:15 p.m. each day of the annual meeting. These informal gatherings are one of the highlights of the annual meeting program.

Tuesday, May 5

HOTEL SCHROEDER

1. **INDICATIONS FOR SURGERY IN GALLBLADDER DISEASE**
   E. H. Ellison, M.D., Milwaukee
2. **IDIOPATHIC ULCERATIVE COLITIS**
   C. Joseph DeLor, M.D., Columbus, Ohio
   Moderator: Joseph Shaiken, M.D., Milwaukee
3. **ETIOLOGICAL FACTORS OF CONGENITAL HEART DISEASE**
   James W. DuShane, M.D., Rochester, Minn.
   Moderator: William Gallen, M.D., Milwaukee
4. **CYSTIC FIBROSIS: A PUBLIC HEALTH CHALLENGE**
   Wynne Sharples, M.D., Boston, Mass.
   Moderator: Virginia Downes, M.D., Milwaukee
   (Following luncheon—open to all MDs—there will be a meeting of the Wisconsin Public Health Physicians)

AUDITORIUM:
Alumni Luncheons (See p. 192)

Wednesday, May 6

HOTEL SCHROEDER

1. **DIFFERENTIAL DIAGNOSIS OF MILD, PAINLESS JAUNDICE**
   James C. Cain, M.D., Rochester, Minn.
   Moderator: J. LeRoy Sims, M.D., Madison
2. **METHODS OF CLOSURE OF ACUTE HAND INJURIES**
   John L. Bell, M.D., Chicago, Ill.
   John C. Kelleher, M.D., Toledo, Ohio
   Moderator: Wm. Frackelton, M.D., Milwaukee
3. **THE ART OF TALKING WITH PARENTS AND NOT TO THEM**
   Sherman Little, M.D., Los Angeles, Calif.
   Moderator: Ely Epstein, M.D., Milwaukee
4. **AMPUTEE REHABILITATION**
   Capt. Thomas J. Canty, MC, USN, Oakland, Calif.
   Moderator: Ray Piaskoski, M.D., Milwaukee
5. **PREINVASIVE CARCINOMA OF THE CERVIX IN PREGNANCY**
   Ronald R. Greene, M.D., Chicago, Ill.
   Moderator: Roland Cron, M.D., Milwaukee
6. **NON-MEDICINAL PRESCRIPTIONS**
   Marc Hollender, M.D., Syracuse, N.Y.
   Moderator: Bernard Kaufman, M.D., Milwaukee
7. **INFECTIONS IN THE NEWBORN**
   Heyworth N. Sanford, M.D., Chicago
   Moderator: H. Kent Tenney, M.D., Madison
8. **THE PLACE OF THE PATHOLOGIST IN A HOSPITAL ISOTOPE PROGRAM**
   Oscar B. Hunter, Jr., M.D., Washington, D.C.
   Moderator: Etheldred Schafer, M.D., Madison
   (Meeting of Wisconsin Society of Pathologists to follow luncheon)

Thursday, May 7

HOTEL SCHROEDER

1. **DIAGNOSIS OF GLAUCOMA**
   John M. McLean, M.D., New York City
   Moderator: F. Jefferson Davis, M.D., Madison
2. **CUTANEOUS MALIGNANCIES**
   Anthony C. Cipollaro, M.D., New York City
   Moderator: Joel Taxman, M.D., Milwaukee
3. **POSTOPERATIVE EXCITEMENT AND RESTLESSNESS**
   Solomon G. Hershey, M.D., New York City
   Moderator: Wilson Phillips, M.D., Milwaukee
4. **FACIAL INJURIES**
   Kenneth Devine, M.D., Rochester, Minn.
   Moderator: Lee Eby, M.D., Milwaukee
5. **NEWER DRUGS AND THEIR USES**
   Ovid O. Meyer, M.D., Madison
6. **CINERADIOGRAPHY**
   J. A. Campbell, M.D., Indianapolis, Ind
   Moderator: Lester W. Paul, M.D., Madison
7. **DIAGNOSIS AND MANAGEMENT OF MALABSORPTION SYNDROME**
   Franz J. Ingelfinger, M.D., Boston, Mass.
   Moderator: M. C. F. Lindert, M.D, Milwaukee
8. **THE ROLE OF TRAUMA IN THE DEVELOPMENT OF PSYCHOSOMATIC DISORDERS**
   E. S. Turrell, M.D., Milwaukee

USE BLANK ON PAGE 198 FOR LUNCHEONS AND ANNUAL DINNER RESERVATIONS

Roster of Distinguished Guests

SMS ANNUAL MEETING, MILWAUKEE, MAY 5-6-7, 1959

ALBERT H. ANDREWS, JR., M. D.
Associate Clinical Professor of Broncho-esophagology, University of Illinois College of Medicine; Director of Respiration Laboratory, St. Luke's Hospital, Chicago, Ill.

JOHN BELL, M. D.
Assistant Professor of Surgery, Northwestern University School of Medicine, Chicago, Ill.

CLIFFORD D. BENSON, M. D.
Associate Professor of Surgery, Wayne State University College of Medicine, and Surgeon-in-Chief, Children's Hospital of Michigan, Detroit, Mich.

JAMES C. CAIN, M. D.
Dept. of Medicine, Mayo Clinic, Rochester, Minn.

JOHN A. CAMPBELL, M. D.
Professor and Chairman of the Dept. of Radiology, Indiana University Medical Center, Indianapolis, Ind.

CAPT. THOMAS J. CANTY, MC, USN
Chief, Amputee Service, U. S. Naval Hospital, Oakland, Calif.

ANTHONY C. CIPOLLARO, M. D.
Director and Professor of Dermatology, New York Polyclinic Medical School, New York City

C. JOSEPH DE LOR, M. D.
Clinical Professor of Medicine, Ohio State University College of Medicine, Columbus, Ohio

EDWARD H. DENNEN, M. D.
Professor of Obstetrics, New York Polyclinic Medical School and Hospital, and Professor of Clinical Obstetrics and Gynecology, Cornell Medical College, New York City

KENNETH DEVINE, M. D.
Assistant Professor of Plastic Surgery, Dept. of Laryngology, Mayo Clinic, Rochester, Minn.

JAMES W. DU SHANE, M. D.
Dept. of Pediatrics, Mayo Clinic, Rochester, Minn.

RONALD R. GREENE, M. D.
Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago, Ill.

SOLOMON G. HERSHEY, M. D.
Clinical Professor of Anesthesiology, New York University Post Graduate Medical School, New York City

FRED J. HODGES, M. D.
Professor and Chairman, Dept. of Radiology, University of Michigan Medical School, Ann Arbor, Mich.

MARC HOLLENDER, M. D.
Professor and Chairman, Dept. of Psychiatry, New York Upstate Medical Center, and Director, Syracuse Psychiatric Hospital, Syracuse, N. Y

OSCAR B. HUNTER, M. D.
Director, Oscar B. Hunter Memorial Laboratory, Washington, D. C.

FRANZ J. INGELFINGER, M. D.
Professor of Medicine, Boston University School of Medicine, Boston, Mass.

JOHN C. KELLEHER, M. D.
Director of Plastic Surgery, Maumee Valley Hospital, and Mercy Hospital, Toledo, Ohio.

EDWIN R. LEVINE, M. D.
Assistant Professor of Clinical Medicine, Chicago Medical School; Chief of the Chest Clinic, Edgewater Hospital, Chicago, Ill.

SHERMAN LITTLE, M. D.
Professor of Pediatrics, and Assistant Professor of Psychiatry, Southern California School of Medicine, Los Angeles, Calif.

IRVING MACK, M. D.
Assistant Clinical Professor of Medicine, Chicago Medical School, Chicago, Ill.

JOHN M. MC LEAN, M. D.
Professor of Clinical Surgery (Ophthalmology) Cornell University Medical College, New York City.

EARL D. OSBORNE, M. D.
Professor of Dermatology and Syphilology, University of Buffalo School of Medicine, Buffalo, N. Y.

HEYWORTH N. SANFORD, M. D.
Professor and Chairman, Dept. of Pediatrics, University of Illinois College of Medicine, Chicago, Ill.

WYNNE SHARPLES, M. D.
President, Cystic Fibrosis Research Foundation, Boston, Mass.

V. K. STOELTING, M. D.
Director, Dept. of Anesthesiology, Indiana University Hospitals, and Professor of Anesthesiology, University of Indiana Medical School, Indianapolis, Ind.

SPECIAL LUNCHEONS

Tuesday, May 5

MARKET HALL, AUDITORIUM
Marquette Alumni: $2.50. Order from Ray H. Pfau, 620 N. 14th St., Milwaukee

JUNEAU HALL, AUDITORIUM
UW Alumni: $2.50. Order from Robert C. Parkin, M.D., 418 N. Randall Ave., Madison

Wednesday, May 6

PERE MARQUETTE ROOM, HOTEL SCHROEDER
Officers and members of the SMS Charitable, Educational and Scientific Foundation

PARLORS E & G, HOTEL SCHROEDER
Clinic Managers

Thursday, May 7

PARLOR G, HOTEL SCHROEDER
Past Presidents

ASSOCIATED DINNERS

WISCONSIN RADIOLOGICAL SOCIETY
(Members and Guests)
Thursday, May 7, 6:30 p.m.
University Club, Milwaukee
Speaker: Fred J. Hodges, M.D., Ann Arbor, Mich.
"Future Opportunities in Radiology"

WISCONSIN PEDIATRICIANS
(Physicians practicing pediatrics in Wisconsin)
Tuesday, May 5, 6:30 p.m.
University Club, Milwaukee

WISCONSIN DERMATOLOGISTS
(Physicians practicing dermatology in Wisconsin)
Thursday, May 7, 6:30 p.m.
University Club, Milwaukee

WISCONSIN SURGICAL SOCIETY
(Members Only)
Thursday, May 7, 6:30 p.m.
Milwaukee Athletic Club
Speaker: C. D. Benson, M.D., Detroit

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS
(Members and Guests)
Thursday, May 7, 6:30 p.m.
Fazio's Restaurant
Films: O. Sydney Orth, M.D., Madison
"Anesthesiology in South America"

EVENING EVENTS

Monday, May 4

BALLROOM, HOTEL SCHROEDER
7:30 p.m.—HOUSE OF DELEGATES

Tuesday, May 5

BALLROOM, HOTEL SCHROEDER
7:30 p.m.—HOUSE OF DELEGATES

EAST ROOM, HOTEL SCHROEDER
8:00 p.m.—FIRESIDE CONFERENCES

A series of informal "problem clinics" presented by the Wisconsin Chapter of the American College of Chest Physicians. Free beer and pretzels. "Table hop" as you wish from informal conference tables provided.

1. **DIAGNOSIS AND MANAGEMENT OF CARDIAC ARRHYTHMIAS**
   Armin R. Baier, M.D., and **Jules Chase, M.D.,** Marquette U., Milwaukee
2. **RECENT DEVELOPMENTS IN CARDIOVASCULAR SURGERY**
   Derward J. Lepley, M.D., Marquette U., Milwaukee; **James W. DuShane, M.D.,** Mayo Clinic, Rochester, Minn., and **William J. Gallen, M.D.,** Marquette U., Milwaukee
3. **PULMONARY HYPERTENSION AND COR PULMONALE**
   Irving Mack, M.D., Chicago, Ill., and **Timothy R. Murphy, M.D.,** Marquette U., Milwaukee
4. **PULMONARY FUNCTION TESTING**
   John Rankin, M.D., U. of W., Madison, and **Walter H. Thiede, M.D.,** Marquette U., Milwaukee
5. **MANAGEMENT OF PULMONARY EMPHYSEMA**
   Edwin R. Levine, M.D., Chicago, Ill., and **Albert H. Andrews, Jr., M.D.,** Chicago, Ill.
6. **PULMONARY FIBROSIS AND PNEUMOCONIOSIS**
   Helen A. Dickie, M.D., U. of W., Madison, and **Richard P. Jahn, M.D.,** Marquette U., Milwaukee
7. **MANAGEMENT OF BRONCHIAL ASTHMA AND OTHER RESPIRATORY ALLERGIES**
   Harold D. Rose, M.D., Marquette U., Milwaukee; **Clifford H. Kalb, M.D.,** Milwaukee, and **John A. Arkins, M.D.,** Marquette U., Milwaukee
8. **MANAGEMENT OF LUNG CANCER INCLUDING CHEMOTHERAPY, PALLIATIVE SURGERY, AND RADIOTHERAPY**
   Anthony R. Curreri, M.D., U. of W., Madison; **Francis B. Landis, M.D.,** Marquette U., Milwaukee, and **Maurice Greenberg, M.D.,** Marquette U., Milwaukee

Wednesday, May 6

EAST ROOM, HOTEL SCHROEDER
6:15 p.m.—President's Reception

BALLROOM, HOTEL SCHROEDER
7:15 p.m.—Annual Dinner

SCIENTIFIC EXHIBITS AND DEMONSTRATIONS

Supplementing the lectures associated with the Annual Meeting the Council on Scientific Work is pleased to present a wide variety of teaching exhibits which have direct value to all physicians attending the Annual Meeting.

Special attention is directed to the Glaucoma Testing Station at the foot of the stage. WE WOULD APPRECIATE YOUR HAVING YOUR TEST BEFORE YOU LEAVE THE MEETING.

ROY B. LARSEN, M.D.
Chairman, Scientific Exhibits

20—TRIACETIN (GLYCERYL TRIACETATE) AS A FUNGICIDE

S. G. Knight, Ph.D., U. of W., and James L. Tuura, M.D., Duluth, Minn.

This exhibit covers research done through the Wisconsin Alumni Research Foundation which establishes a principle of therapy now applicable to superficial fungus infections of the skin. The application of the research was conducted at the University of Wisconsin, in cooperation with the Medical School and the College of Agriculture.

21—SPECIAL EXHIBIT ON CANCER

Wisconsin and Milwaukee Divisions of the American Cancer Society

47—PRIMARY AND SECONDARY PLASTIC REPAIR OF INJURY

Sidney K. Wynn, M.D., Marq. U., Milwaukee

By use of colored diagrams the exhibit illustrates the correct and incorrect methods of suturing lacerations. Case illustrations with descriptive material of different types of injuries and methods of handling will be incorporated in the display.

48—REPAIR OF NASAL DEFECTS WITH EAR LOBE GRAFTS

Frank R. Bernard, M.D., D.D.S., and Gordon Davenport, M.D., U. of W., Madison

This exhibit will present a simplified method of repair of defects of the nose, using the ear lobe as a graft.

48A—UROGENIC SPONDYLITIC OSTEOMYELITIS

Drs. J. W. Pick, C. R. Marquardt, Abraham Melamed, Abraham Marck, and J. M. McGuire, Evangelical Deaconess Hospital, Milwaukee

Two cases of pyelonephritis and one of transurethral prostatic resection are presented with osteomyelitis of the lumbar spine as a complication in each.

Anatomic drawings from authentic specimens are exhibited to demonstrate the peculiarities of left, as compared with the right, renal venous drainage pointing the pathway by which vascular dissemination of sepsis may spread to the spine, meninges or spinal cord from the left kidney. Similarly, Batson's venous system explains mycotic embolic spread from periprostatic venous plexus to the spine.

Roentgen aspects of differentiation of spinal sepsis as contrasted with degenerative intervertebral disk disease and chronic hypertrophic osteomyelitis are illustrated.

49—TRANSVERSE FETAL PRESENTATION

Edgar Habeck, M.D., Evangelical Deaconess Hospital, Milwaukee

Etiology, diagnosis, prognosis and treatment of twenty-two cases of transverse fetal presentations constitutes the exhibit.

50—DEMONSTRATION OF THE ARTIFICIAL KIDNEY

Drs. James Means, Roland Herrington, Robert Haukohl, Yoshiro Taira, and Charles Marquardt, Evangelical Deaconess Hospital, Milwaukee

The indications for and the operation of an artificial kidney are presented, both by way of descriptive material and in the form of a demonstration of equipment.

75-6—REDUCTION OF INTRACRANIAL PRESSURE WITH UREA SOLUTION

Manucher Javid, M.D., UW Medical School, Madison

The exhibit consists of charts and photographs, illustrating the experiences with the administration of urea in 450 patients, as well as 100 studies in Rhesus monkeys, experimentally. Supplementing the charts and photographs there is a continuous showing of illustrative slides.

76A—DIAGNOSIS AND SURGICAL MANAGEMENT OF ACQUIRED VALVULAR HEART DISEASE

Cardiovascular Unit of UW Medical School, Madison

The diagnostic aspects, both clinical and those obtained from cardiac catheterization, of acquired heart disease, affecting the mitral and aortic valves is presented. This is supplemented by a presentation of the pertinent pathology as well as the currently applied surgical procedures utilized in the management of acquired valvular heart disease.

76B—SMEAR AND BIOPSY AIDS IN OFFICE GYNECOLOGY

Drs. F. J. Hofmeister, C. W. Wolfe, and D. Carlson, Milwaukee Hospital and Marquette U. School of Medicine

This exhibit pictorially illustrates by means of Kodachrome photomicrographs the significant characteristic findings of diagnostic smear and tissue aids in office gynecology. Demonstrations are of Papanicolau smears with illustrations of their value in detecting malignancy, in determining ovarian function, and their possible value in detecting trichomonas infection. The malignant phase of positive Papanicolau smears is correlated with photomicrographs of cervical biopsies. A demonstration of photomicrographs of rou-

(continued)

tine endometrial samplings is presented. Characteristic findings and the significance of the ferning phenomena of cervical mucus is illustrated. Illustrations of typical variations in the vaginal flora from the normal Döderlein bacillus through mixed vaginal flora including moniliasis infection and trichomonas infection is shown. Where possible, statistical efforts are cited.

(Exhibit at end of booths 48A and 76A, facing stage)

101—DIRECT SURGERY OF THE PERIPHERAL ARTERIAL TREE

Drs. J. T. Phelan and W. P. Young, UW Medical School, Madison

The direct surgical approach to occlusive disease of the arterial system has now become a well established surgical procedure. This exhibit shows some of the common arterial disease conditions, methods of diagnosis, and surgical procedures employed to correct the underlying vascular disease problem.

102—SEGMENTAL CONSOLIDATION OF THE LUNG

J. R. Johnson, M.D., VA Hospital, Madison, and the Wisconsin Anti-Tuberculosis Association

The exhibit consists of twenty-five sets of PA and lateral chest films, demonstrating individual consolidations of the lobes and segments of the lung. A plastic model illustrates their roentgenographic outline.

103—SMALL VESSEL ANASTAMOSES

Marvin Glicklich, M.D., Marquette U. School of Medicine, Milwaukee

A controlled study of anastamoses of small arteries 4 to 2 millimeters external diameter after simple division has been undertaken. Results using a 7–0 monofilament stainless steel suture are compared to those with 7–0 braided silk suture. Both superficial femoral arteries of 10 to 30 pound dogs have been utilized, each pair of vessels providing its own comparison, in this first phase of the study.

The data and follow-up of 25 dogs (50 vessel anastamoses) up to 10 months postoperatively is tabulated. Follow-up has consisted of palpation of the vessel pulse, arteriograms, exploration of the vessel, excision of the vessel, and histologic examination of the anastamotic site. Colored photographic enlargements of the vessels and transparencies of the arteriograms are presented. A standard method of dividing and anastamosing them has been outlined. No anticoagulants were used in this series. Factors involved in the failures are analyzed.

(This study was supported by a research grant from the Wisconsin Heart Association)

104–5—THE ULCEROGENIC TUMOR OF THE PANCREAS

Drs. E. H. Ellison and Thomas Wall, Marquette U. School of Medicine, Milwaukee

The exhibit consists of a summary of 83 instances of intractable peptic ulcer associated with noninsulin producing islet cell (delta) tumor of the pancreas, with emphasis on diagnosis and suggested methods of management.

106—POLAROID PHOTOGRAPHY ON SURGICAL SPECIMENS

E. S. Olson, M.D. and Mr. Wood, St. Luke's Memorial Hospital, Racine

This consists of a demonstration to illustrate how the taking of polaroid photographs of surgical specimens can be completed in a matter of minutes and attached to laboratory reports. The exhibit is based upon experience in the clinical laboratory of St. Luke's Hospital, Racine.

107—BLUNT ABDOMINAL TRAUMA

Medical staffs of Milwaukee Hospital and Milwaukee Children's Hospital, Milwaukee

The exhibit illustrates six of the more common lesions following blunt abdominal trauma. Significant physical findings, history and radiology will be presented in each case. Important factors in mortality and cardinal principles in surgical management are outlined.

108—GROSS TISSUE DEMONSTRATIONS

SMS Section of Pathology and the Wisconsin Society of Pathologists

Members of the Society will conduct daily demonstrations of surgical and autopsy tissue.

109—RESEARCH PROJECTS OF COLUMBIA HOSPITAL, MILWAUKEE

Medical staff of Columbia Hospital, Milwaukee

The exhibit will cover the following subjects:

CLOSURE AND SUPPORT OF THE VAGINAL VAULT IN VAGINAL HYSTERECTOMY
M. A. Krembs, M.D.

MANAGEMENT OF ARTERIAL INJURIES
J. E. Conley, M.D., and J. M. Sullivan, M.D.

MUSCLE BIOPSY: USES AND LIMITATIONS
R. R. Koenig, M.D., and Gorton Ritchie, M.D.

110—THE USE OF TIDAL DRAINAGE IN THE BLADDER TRAINING OF PATIENTS WITH CORD LESIONS OR OTHER NEUROLOGICAL DISABILITIES

Departments of Physical Medicine and Rehabilitation, Marquette U. School of Medicine, Milwaukee, VA Hospital, Wood, and Milwaukee County Hospital; and the Department of Urology, VA Hospital, Wood

The central attraction of this exhibit is a tidal draining mock-up, demonstrating how it works. Panels of transparencies give the indications, uses, and contraindications in determining the need for this type of setup.

111—SODIUM AND WATER HOMEOSTASIS IN HYPERNATREMIC INFANTS

Gerald A. Kerrigan, M.D., Milwaukee Children's Hospital, Milwaukee, and Marquette U. School of Medicine, R. L. Arends, Ph.D., and I. Held, B.S.

Figures illustrating Na and K homeostasis in infants recovering from diarrhea, studied by balance technique, are featured in this exhibit.

112—SELECTIVE CINEFLUOROGRAPHY OF THE HEART

Drs. William J. Gallen and D. P. Babbitt, Milwaukee Children's Hospital, Milwaukee, and

PHENYLKETONURIA: A PREVENTABLE FORM OF MENTAL DEFICIENCY
Drs. Stanley Berlow and Lucille B. Glicklith, Milwaukee Children's Hospital, Milwaukee

These two exhibits present illustrative material showing methods used in the procedures outlined in the titles listed.

(continued)

SCIENTIFIC EXHIBITS (continued)

113—SURGERY OF THE TEMPOROMANDIBULAR JOINTS

R. P. Gingrass, M.D., Milwaukee

This exhibit consists of Kodachrome transparencies illustrating surgical diseases of the mandibular joints such as ankylosis, hyperostosis, tumors, and fracture-dislocations. Roentgen negatives also are exhibited on specially made viewing boxes.

Charts illustrating results with injections for stabilization and for chronic traumatic arthritis are shown.

Results following a large number of meniscectomies and high condylectomies for chronic traumatic arthritis are presented.

114—NORMAL AND ABNORMAL CARDIOVASCULAR DYNAMICS

John Huston, M.D., Marquette U. School of Medicine and the Wisconsin Heart Association

A model of the circulation which graphically illustrates cardiovascular hydrodynamics has been designed and used with success in teaching hemodynamics to under graduate and graduate students of medicine, as well as in the analysis of problems in normal and abnormal cardiovascular hydrodynamics. The model demonstrates certain aspects of Starling's law of the heart, and the effects of changes in the peripheral resistance. It permits first hand observation of various factors affecting the circulation. It is constructed so that the progressive effects of various lesions leading to congestive circulatory, auricular and ventricular dilatation, pulmonary edema, and other consequences can be observed.

115A—ENHANCED IRON ABSORPTION WITH A NEW HEMATINIC

Donald C. Ausman, M.D., Evangelical Deaconess Hospital, Milwaukee

The exhibit presents the indications, advantages, administration, toxicity and clinical responses to the use of a new agent, to show how much faster iron is absorbed into the system if a "wetting agent" is added. The research was done by the author and associates at the hospital indicated.

127—CAUSES OF HEMOPTYSIS

Drs. O. F. Foseid, J. W. Messer, and W. L. Waskow, Jackson Clinic, Madison

The exhibit consists of a series of chest x-ray films, set in panels, illustrating various causes of hemoptysis. Each film has a brief summary and diagnosis at the bottom.

128-29-30—GLAUCOMA DETECTION SCREENING STATION

Wisconsin Committee of the National Association for the Prevention of Blindness

This important exhibit is furnished for the purpose of screening all physicians in attendance, to ascertain potential glaucoma. The booth provides an area where vision is tested, following which the tension on each eye is measured, using a Schiotz tonometer, while the physician being tested is recumbent, on a table. In addition to the actual testing the exhibit includes a series of transparencies, showing the differences in acute and chronic types of glaucoma, various types of tests for glaucoma, field changes, etc.

It is important that every physician in attendance participates in this demonstration, so please plan your schedule accordingly.

• EXHIBITS ON STAGE

PROPHYLACTIC USE OF RADIOACTIVE GOLD IN THE TREATMENT OF CANCER OF THE OVARY

I. I. Cowan, M.D., and associates, Marquette U. School of Medicine, Milwaukee

The exhibit presents an evaluation of the clinical results of treatment of 33 cases of cancer of the ovary, from January 1952 to December 1958. By statistical summary it shows that there are fewer complications in the treatment of cancer of the ovary, especially the occurrence of ascitics as a complication. The overall five-year results seem to indicate that the survival rate has been improved over the conventional treatment . . . surgery, plus external irradiation.

RESPIRATORY AND REHABILITATION CENTERS

A. A. Siebens, M.D., UW Medical School, Madison

The exhibit outlines the activities and services of a respiratory and rehabilitation center as established and in operation at the University of Wisconsin Medical School.

THE VITAL LINK: FOLLOW-UP

Richard P. Jahn, M.D., Milwaukee and Wisconsin Anti-Tuberculosis Association

To demonstrate the importance of minimum delay in handling chest conditions, this exhibit displays several pertinent cases, as well as a number of related unknown cases. It also illustrates the joint film registry of the Milwaukee County TB Control Division and the Wisconsin Anti-Tuberculosis Association, and a report on a special case-finding project in Milwaukee.

IS THE PAPANICOLAU SMEAR REPLACING THE BIOPSY IN CANCER OF THE CERVIX?

Department of Obstetrics and Gynecology, Milwaukee County Hospital

The tumor board of Milwaukee County presents an exhibit to support the thesis that with close observation of the "Paps" Smear it is not necessary to biopsy cervices, and in the smears to perform a cone of the cervix. The display also demonstrates the ineffectiveness of endometrial biopsy and aspiration in diagnosing cancer of the endometrium.

• HALLWAY LEADING TO MEETING ROOMS

DIAGNOSTIC CASE OF THE DAY

Department of Radiology, University Hospitals, Madison

A different radiologic "case of the day" will be presented each day. After the visitor makes his diagnosis, the final histopathologic diagnosis will be available to him.

CHROMATOGRAPHY IN LABORATORY MEDICINE

Laboratory Staff, St. Joseph Hospital, Milwaukee

The exhibit undertakes to outline the principles of chromatography, to demonstrate the application of these simple techniques and to illustrate some interesting clinical results.

TECHNICAL EXHIBITS

42—ABBOTT LABORATORIES, North Chicago, Ill.

121—AMERICAN FERMENT CO., INC., New York, N. Y.

87—AMES CO., INC., Elkhart, Ind.

117—AUDIO-DIGEST FOUNDATION, Glendale, Calif.

31—AYERST LABORATORIES, Chicago, Ill.

19—ROBERT W. BAIRD CO., Milwaukee, Wis.

126—BARR X-RAY CO., INC., Morton Grove, Ill.

72—BELTONE HEARING SERVICE, Milwaukee, Wis.

40—BENSON OPTICAL CO., Minneapolis, Minn.

86—HOUSE OF BIDWELL, Milwaukee, Wis.

26—BORDEN CO., New York, N. Y.

25—BORCHERDT CO., Chicago, Ill.

30—BROOK HILL FARMS, Chicago, Ill.

39—BROOKS APPLIANCE CO., Chicago, Ill.

27—BURROUGHS WELLCOME & CO., INC., Tuckahoe, N. Y.

97—S. H. CAMP & CO., Jackson, Mich.

92—CARNATION CO., Los Angeles, Calif.

43—CHICAGO PHARMACAL CO., Chicago, Ill.

70—CIBA PHARMACEUTICAL PRODUCTS, INC., Summit, N. J.

74—COCA COLA CO., Milwaukee, Wis.

66—DESITIN CHEMICAL CO., Providence, R. I.

122—DICTAPHONE CORP., New York, N. Y.

83—DOHO CHEMICAL CORP., New York, N. Y.

73—EATON LABORATORIES, Norwich, N. Y.

45—ENCYCLOPAEDIA BRITANNICA, Chicago, Ill.

2—ENDO LABORATORIES, INC., Richmond Hill, N. Y.

17-18—MARSHALL ERDMANN AND ASSOCIATES, Madison, Wis.

89—EVRON CO., INC., Chicago, Ill.

16—A. J. FARNHAM CO., INC., Milwaukee, Wis.

99—C. B. FLEET CO., INC., Lynchburg, Va.

36—E. FOUGERA AND CO., INC., New York, N. Y.

59—GEIGY PHARMACEUTICALS, Yonkers, N. Y.

1—GENERAL ELECTRIC CO. (X-RAY DIVISION), Milwaukee, Wis.

28—GERBER PRODUCTS CO., Fremont, Mich.

91—HOFFMAN-LA ROCHE, INC., Nutley, N. J.

84-100—HURLEY X-RAY CO., Milwaukee, Wis.

82—C. B. KENDALL CO., Indianapolis, Ind.

29—KNOLL PHARMACEUTICAL CO., Orange, N. J.

4—KREMERS-URBAN CO., Milwaukee, Wis.

8-9—LAKESIDE LABORATORIES, INC., Milwaukee, Wis.

88—LANGER LABORATORIES, INC., Milwaukee, Wis.

44—LEDERLE LABORATORIES (DIVISION OF AMERICAN CYANAMID CO.), Pearl River, N. Y.

41—ELI LILLY AND CO., Indianapolis, Ind.

98—LINCOLN LABORATORIES, INC., Decatur, Ill.

10—J. B. LIPPINCOTT CO., Philadelphia, Pa.

81—LLOYD BROTHERS, INC., Cincinnati, Ohio

67—LOV-E BRASSIERE CO., Hollywood, Calif.

3—MAICO HEARING SERVICE, Milwaukee, Wis.

79—MALTBIE LABORATORIES (DIVISION OF WALLACE & TIERNAN, INC.), Belleville, N. J.

69—S. E. MASSENGILL CO., Bristol, Tenn.

118—MEAD JOHNSON AND CO., Evansville, Ind.

51—MEDCO PRODUCTS CO., Tulsa, Okla.

53—THE MEDICAL PROTECTIVE CO., Ft. Wayne, Ind.

115—MEDICO-MART, INC., Milwaukee, Wis.

68—MERCK, SHARP AND DOHME, Philadelphia, Pa.

63—WILLIAM S. MERRELL CO., Cincinnati, Ohio

64—MEYER AND CO., Detroit, Mich.

15—MILEX-ALPHA PRODUCTS, Evanston, Ill.

55—V. MUELLER AND CO., Chicago, Ill.

119—JOHN NICHOLS, INC., Milwaukee, Wis.

65—ORGANON, INC., Orange, N. J.

32—ORTHO PHARMACEUTICAL CORP., Raritan, N. J.

46—ORTHOPEDIC APPLIANCE CO., INC., Milwaukee, Wis.

94—PENGELLY X-RAY CORP., Milwaukee, Wis.

35—PET MILK CO., St. Louis, Mo.

125—PFIZER LABORATORIES, INC., Brooklyn, N. Y.

37—PHYSICIANS AND HOSPITALS SUPPLY CO., Minneapolis, Minn.

6—PROFESSIONAL BUSINESS SERVICE, La Crosse, Wis.

13—PROFESSIONAL OFFICE BUILDINGS, INC., Madison, Wis.

90—PURDUE FREDERICK CO., New York, N. Y.

116—R. J. REYNOLDS TOBACCO CO., Winston-Salem, N. C.

95—RIKER LABORATORIES, INC., Northridge, Calif.

78—ROBERTSON'S, INC., Milwaukee, Wis.

58—A. H. ROBINS COMPANY, INC., Richmond, Va.

123-124—ROEMER-KARRER CO., Milwaukee, Wis.

61—J. B. ROERIG AND CO., New York, N. Y.

22—WILLIAM H. RORER, INC., Philadelphia, Pa.

71—ROSS LABORATORIES, Columbus, Ohio

52—SANBORN CO., Waltham, Mass.

57—SANDOZ PHARMACEUTICALS, Hanover, N. J.

62—W. B. SAUNDERS CO., Philadelphia, Pa.

11—SCHERING CORP., Bloomfield, N. J.

96—SCHIEFFLIN & CO., New York, N. Y.

12—G. D. SEARLE AND CO., Chicago, Ill.

77—7-UP DEVELOPER'S ASSOCIATION OF WISCONSIN, INC., Milwaukee, Wis.

14—SLATEN INSTRUMENT MFG. CO., Milwaukee, Wis.

5—SMITH, KLINE AND FRENCH LABORATORIES, Philadelphia, Pa.

56—E. R. SQUIBB AND SONS, New York, N. Y.

60—STUART CO., Chicago, Ill.

23—THERMO-FAX CORP., Milwaukee and Madison, Wis.

38—ULMER PHARMACAL CO., Minneapolis, Minn.

34—UPJOHN CO., Kalamazoo, Mich.

80—U. S. STANDARD PRODUCTS CO., Mt. Prospect, Ill.

7—U. S. VITAMIN CORP., New York, N. Y.

24—WARNER-CHILCOTT LABORATORIES, Morris Plains, N. J.

33—WESTWOOD PHARMACEUTICALS, Buffalo, N. Y.

54—WINTHROP LABORATORIES, New York, N. Y.

120—WYETH LABORATORIES, Philadelphia, Pa.

93—ZIMMER MFG. CO., Warsaw, Ind.

Program Highlights of Woman's Auxiliary

Tuesday, May 5

ENGLISH ROOM, HOTEL SCHROEDER

6:30 p.m.—Board of Directors Meeting

Wednesday, May 6

LORRAINE ROOM, HOTEL SCHROEDER

8:30 a.m.—Sun-up Time Continental Breakfast

10:00 a.m.—Business Meeting

Mrs. G. J. Schulz, President, Union Grove, presiding

Mrs. E. A. Underwood, National President of Woman's Auxiliary to AMA, Vancouver, Wash., guest speaker

CRYSTAL BALLROOM, HOTEL SCHROEDER

1:00 p.m.—Luncheon honoring Mrs. E. A. Underwood

Miss Norma Lee Browning, CHICAGO TRIBUNE Reporter, guest speaker

Thursday, May 7

LORRAINE ROOM, HOTEL SCHROEDER

8:30 a.m.—Sun-up Time Continental Breakfast

10:00 a.m.—Business Meeting

Mrs. G. J. Schulz, President, Union Grove, presiding

Election and Installation of New Officers

CRYSTAL ROOM, HOTEL PFISTER

1:00 p.m.—Luncheon

Mrs. G. A. Behnke, New President, Kaukauna, presiding

Special entertainment by a Folk Group of the Hellenic Community

RESERVATION FORMS FOR

Roundtable Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 3 Choices for each of the days you make reservations. List in order of preference. $2.50 per luncheon, including gratuities.

TUESDAY, MAY 5 (See page 190 for listing)

IMPORTANT: Those making reservations for the Marquette and U. of W. Alumni luncheons please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. ELLISON: "GALLBLADDER DISEASE"
2. DE LOR: "ULCERATIVE COLITIS"
3. DU SHANE: "CONGENITAL HEART DISEASE"
4. SHARPLES: "CYSTIC FIBROSIS"

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

WEDNESDAY, MAY 6 (See page 190 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. CAIN: "MILD, PAINLESS JAUNDICE"
2. BELL & KELLEHER: "CLOSURE OF HAND INJURIES"
3. LITTLE: "TALKING WITH PARENTS"
4. CANTY: "AMPUTEE REHABILITATION"
5. GREENE: "CA OF THE CERVIX IN PREGNANCY"
6. HOLLENDER: "NON-MEDICINAL PRESCRIPTIONS"
7. SANFORD: "INFECTIONS OF THE NEWBORN"
8. HUNTER: "THE PATHOLOGIST IN A HOSPITAL ISOTOPE PROGRAM"

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

THURSDAY, MAY 7 (See page 190 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. McLEAN: "GLAUCOMA"
2. CIPOLLARO: "CUTANEOUS MALIGNANCIES"
3. HERSHEY: "POSTOPERATIVE EXCITEMENT"
4. DEVINE: "FACIAL INJURIES"
5. MEYER: "NEWER DRUGS AND THEIR USES"
6. CAMPBELL: "CINERADIOGRAPHY"
7. INGELFINGER: "MALABSORPTION SYNDROME"
8. TURRELL: "TRAUMA AND PSYCHOSOMATIC DISORDERS"

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

ANNUAL DINNER, Wed., May 6

DANCING—FLOOR SHOW
SHORT SPEECHES—COCKTAILS

$6.50 PER PERSON (Including Gratuities)

Number Luncheon Tickets ($2.50 each) . . . . . _____ for $_____

Number Annual Dinner Tickets ($6.50 each) . . _____ for $_____ TOTAL $_____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ STREET _____ CITY _____
(Print, please)

MAIL TO: State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin

THE WISCONSIN MEDICAL JOURNAL

Volume 58 APRIL 1959 Number 4

Hereditary Spherocytosis: A Review*

By ARCHIE MacKINNEY, JR., M. D.**

Madison, Wisconsin

THE PURPOSE OF THIS paper is to review some of the extensive literature on hereditary spherocytosis and to present findings from our study of 35 patients with this disease and 50 blood relatives from 11 families.

Hereditary spherocytosis is one of the inherited hemolytic anemias which include thalassemia, sicklemia and other hemoglobinopathies, hereditary elliptocytosis, and nonspherocytic hemolytic anemia. It is also called familial hemolytic anemia and spherocytic icterus, but these terms are inaccurate since the patient may be neither anemic nor icteric. Hereditary spherocytosis describes more exactly a disease which is an inherited dominant trait and which is due to a globular red cell.

The disease has been known for over 80 years, since it was first described by Vanlair and Masius in 1871.[1] At least seven genetic studies have been reported, beginning with those by Meulengracht[2] and including more recently, the studies by Young, Izzo and Platzer.[3] These studies leave little doubt that hereditary spherocytosis is a dominant trait. In Race's[4] large series of 183 members of 26 families, however, there was less than the predicted number of affected siblings, thought due to increased miscarriage rate and increase in mild, undetected cases. This has not been demonstrated in our series.†

The disease is clearly due to a defect in the red cell itself, recent evidence suggesting a disorder of carbohydrate metabolism. The spherocyte has a decreased diameter and increased thickness compared to normal cells. Its surface area is reduced while its volume remains normal.[5] The spherical shape is probably an adaptation required to contain the cell contents within the least possible surface area. Mechanical trauma, reduced osmotic pressure, and incubation at body temperature cause greatly increased rates of hemolysis, suggesting a membrane which is much more fragile than the normal.

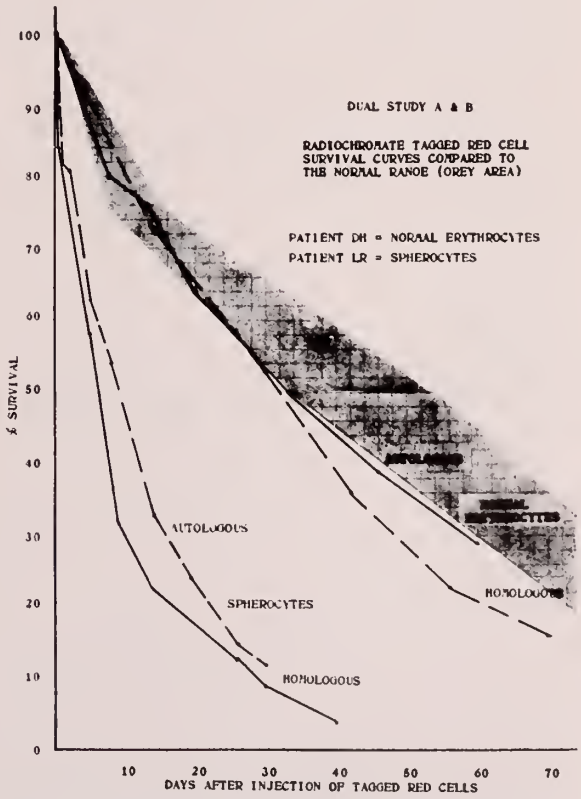


Fig. 1—The broad gray band indicates the normal chromium51 half-life range as 32 to 54 days. Note dotted line marked "autologous spherocytes" with half-life of nine days.

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† Unpublished data.

The life of the spherocyte is shortened to from ½ to ⅕ of normal in a group of cases studied here,[6] measured by Cr^{51} method. A typical curve (fig. 1) for normal and spherocytic cells shows the marked shortening of life span of the spherocyte. This shortened life span is not due to circulating hemolytic factors. Although occasional reports of positive Coombs' tests are found in the literature,[7] it is not likely that auto-immune antibodies play a significant role in the mechanism of this disease. Normal cells have repeatedly been found to survive normally in the blood stream of the spherocytic patient, whereas spherocytic cells have a typically shortened life span in the circulation of a normal individual (fig. 2).

Although the defect is intrinsic to the spherocyte, the spleen plays an important role in the disease: striking relief of hemolysis by splenectomy without markedly changing the red cell abnormality supports this concept. Two splenic processes are involved: trapping and lysis.

Emerson, *et al.*, in 1947 demonstrated that spherocytes transfused into patients without hemolytic anemia were rapidly sequestered by the spleen.[8] Weisman, *et al.*, transfused 200 cc. of spherocytic cells into a patient with idiopathic thrombocytopenic purpura and found only 3% of the cells in circulation after 45 hours; 49% were found in the spleen.[9] Young, *et al.*, perfused spleens with mixtures of normal and spherocytic cells and demonstrated that the proportion of spherocytes decreased in the circulatory fluid and that a high percentage could be extracted from the spleen.[10] Whipple believes that this

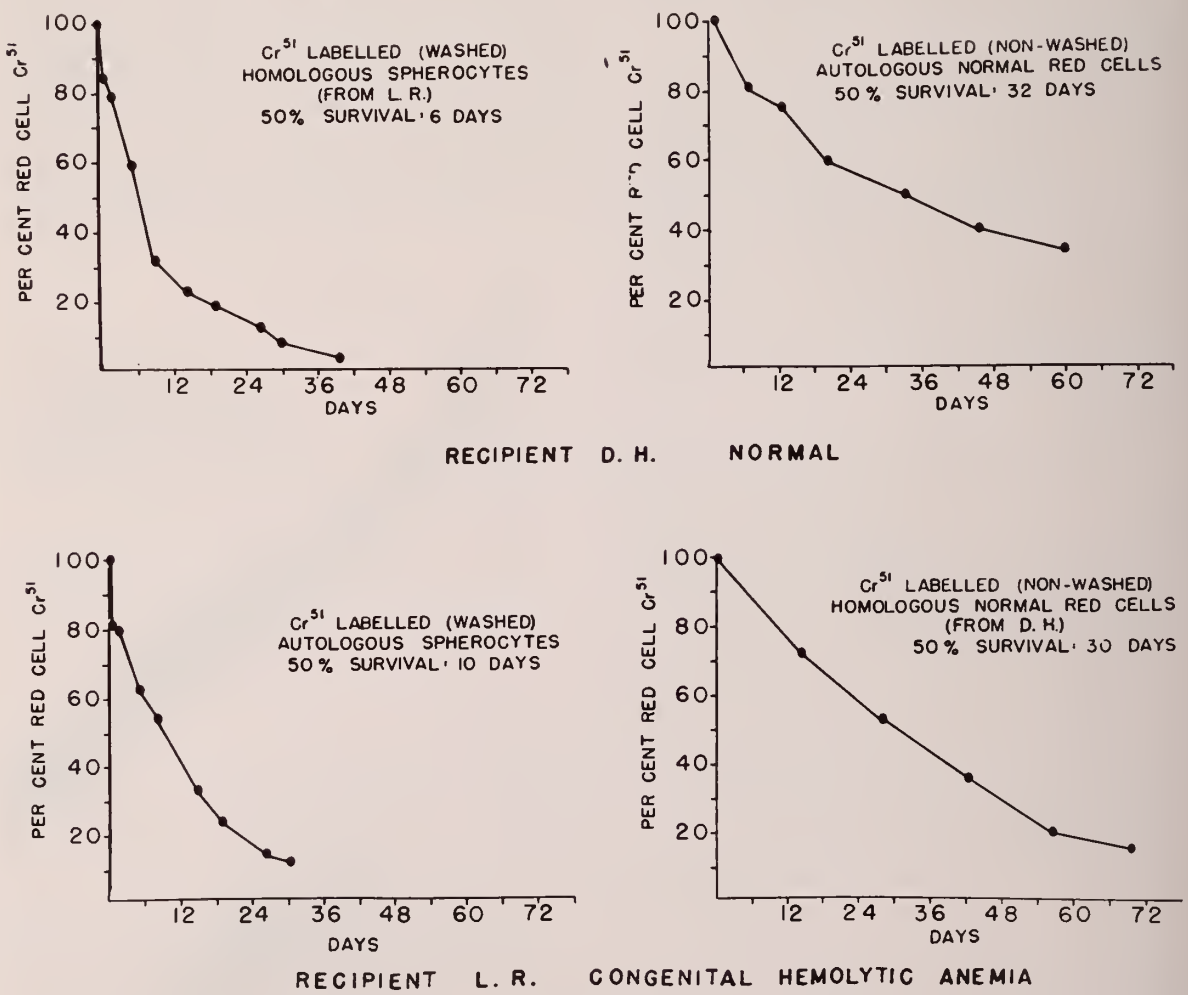

Fig. 2—The upper graphs show the shortened survival of spherocytes transfused into a normal subject on the left versus the normal survival of a transfusion of his own cells on the right.

The lower graphs show the shortened survival of a transfusion of the spherocytic patient's own cells on the left versus the normal survival of normal cells in the circulation of the spherocytic patient.

(Modified from Schloesser, *et al.*, by permission from the *Journal of Clinical Investigation*, October, 1957.)[6]

rounded cell is unable to pass through the slit-like openings in the venous sinuses of the spleen and is exposed for prolonged periods to some lytic factor.[11]

No lytic factor of significance has been found in hereditary spherocytosis, however. Studies showing shortened life span of normal cells transfused into hereditary spherocytosis patients during crisis have been reported,[12] suggesting a superimposed autoimmune mechanism. The bulk of evidence, however, points to a defect in carbohydrate metabolism.

The first clue to such a defect came when, in 1940, Ham and Castle[13] demonstrated that sterile incubation of spherocytes produced earlier hemolysis than with normal cells. Selwyn and Dacie[14] later showed that the high rate of autohemolysis could be markedly reduced by glucose. Similar inhibition can be produced by fructose, mannose, or pentose nucleotides.[15] These observations suggest that the spherocyte will survive nearly normally if enough energy source is supplied to it, in contrast to the normal cell which easily withstands deprivation of substrate for 48 hours. If it could be shown that such deprivation occurs in the spleen, the mechanism of hemolysis in hereditary spherocytosis might be explained. In fact, the amount of plasma content available to nourish the cells is markedly decreased, since intense hemoconcentration does occur with hematocrits averaging 80% in dogs.[16] It is the belief of most investigators that *in vitro* autohemolysis is a model of *in vivo* splenic lysis.

Clinical manifestations of the disease vary widely. Three common clinical situations have come to our attention:

(1) The patient who visits the physician for a routine checkup or who is admitted to the hospital with another illness, and in the course of routine laboratory evaluation is discovered to have a bilirubin of 2.0 mg. % or hemoglobin of 10 gm.
(2) The child who becomes unusually ill with every minor infection and is brought to the physician because he is run-down and pale.
(3) The young adult who becomes suddenly icteric and is hospitalized with symptoms of cholecystitis.

On routine physical examination, pallor and icterus may or may not be evident. The spleen was palpable in 80% of our patients but was not huge.

The most common complication is the hypoplastic or aplastic crisis. This is often called "hemolytic" crisis, although Owren[19] reported in 1948 that an acute aplastic crisis was present in his six patients. Reticulocytes disappear from the peripheral blood, and bilirubin falls as the patient becomes rapidly anemic; leukopenia may be present. With bone marrow temporarily shut down and red cell life span being 8 to 14 days, it is not surprising to find that the hemoglobin has fallen 50% in one to two weeks of febrile illness. All affected members of a family may have simultaneous crisis, for example, when "flu" strikes.[20]

The increased incidence of gallbladder disease is reported by Bates and Brown.[21] This complication may be found at an early age, and it was present in one of their patients, a child of less than 10 years. Bilirubin gallstones presumably develop because of the high concentration of pigment in biliary secretion.

A rare complication is the leg ulcer, not associated with varicose veins, which responds to splenectomy. None was found in this series.

The laboratory diagnosis of hereditary spherocytosis is not difficult using three easily available tests: the blood smear, the reticulocyte count and the bilirubin.

(1) The Wright-stained blood smear demonstrates the typical spherocyte: a small, round, dense cell with loss of central pallor. The changes may be subtle and detected only by trained technicians who are alerted to this disease.
(2) The reticulocytes are increased as part of the increased rate of red cell formation. Of 16 patients studied in this laboratory before splenectomy, the reticulocyte counts varied from 6% to 20% (the normal for this labatory is 2% to 4%).
(3) The indirect bilirubin is usually, but not invariably, elevated. In our series, the indirect fraction averaged 1.6 mg. % (upper limit of normal, 1.1 mg. %), but 1/3 of the patients had normal values.

The combination of blood smear showing numerous spherocytes, an elevated reticulocyte count, and increased indirect bilirubin in more than one member of a family is sufficient to make the presumptive diagnosis of hereditary spherocytosis.

More elaborate and more definitive tests include direct and incubated osmotic fragility, mechanical fragility, and autohemolysis. Of these, the best known and least valuable in our experience has been the osmotic fragility, since it has been positive mainly in the severely affected cases where diagnosis is not a problem.

The mechanical fragility is measured by rotating ½ ml. of blood with ten glass beads in an Erlenmeyer flask at 36 r.p.m. for an hour. This test, first developed by Shen, Castle and Fleming in 1944[22] is perhaps the best single screening test in diagnosing hereditary spherocytosis.

Autohemolysis is the measurement of hemoglobin released from blood incubated under sterile conditions for 48 hours. It is probably better considered a research tool than a practical laboratory test.

One reason for stressing the importance of hereditary spherocytosis is that therapy is well established and almost invariably beneficial. Lawrence Young has aptly said: "In few other chronic diseases can the surgeon offer the patient so much."[23] Splenectomy has been uniformly successful and can be recommended with conviction in even mild cases in order to avoid the hazard of gallbladder disease and aplastic crisis. Mortality is very low in splenectomy for hereditary spherocytosis. In 1955, Cole, *et al.*,[24] reported 137 cases of splenectomy in various diseases, with an over-all mortality of 7.3%. In a group of 40 with hereditary hemolytic anemia, 32 of whom had hereditary spherocytosis, no deaths occurred. Until the exact genetic flaw is found, splenectomy will continue to be valuable therapy in this potentially dangerous disease.

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Pelvic Pain*

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PELVIC PAIN as a chief complaint is encountered in women about as frequently as headache, indigestion, and backache. In fact, pain originating in the pelvis is often expressed in terms of low backache and occurs with existing demonstrable pelvic pathology.

One may theorize on the mechanism of the so-called "pelvic autonomic syndrome" without arriving at a thoroughly satisfactory explanation. Pain impulses from pelvic viscera course through the somatic afferent nerve fibers, called the visceropelvic nerves, passing upward in the sympathetic chain to the spinal cord at the proper level stations where the impulses are sorted out; and by the "visceromotor" reflex the person is aware of the general location of the origin of the impulse. The frequent vagueness of localization is thought to be due to the minute size and ramifications of the sensory nerves. Sometimes pelvic pain may arise, not from pelvic organs, but from abdominal wall sites, either anterior, lateral, or posterior in the skeletal back. Genital sites of pain may be manifested as low back pain, but rarely do skeletal origins cause pelvic pain.

Guerriero and Stuart[1] presented an excellent review of the basic anatomy and physiology concerned with gynecologic pain and pain which simulates it. The area involved is often below a line drawn from each of the anterior iliac spines to the umbilicus, and may involve the vulva or the medial aspect of the thighs extending about one-third of the distance to the knees. These areas are identical with the area of pain occurring with labor and with dysmenorrhea. The chief nerve supply to the area is the first lumbar nerve, and the "visceromotor" reflex is the modus operandi. This would be a relatively simple explanation of the mechanism of pelvic pain if it were not known that the autonomic nerve supply to the genital tract comes from more than two sympathetic and one parasympathetic source. The utero-ovarian plexuses are derived from the last three thoracic and first lumbar cord segments, and the fibers pass by way of the renal and intermesenteric plexus through the infundibulopelvic ligament to mesosalpinx and to the hilus of the ovary spreading out even under the serosal surface. Fibers from the first three lumbar segments pass through the inferior mesenteric plexus and become the superior hypogastric plexus, or presacral nerve, on the anterior sacral surface, then divide to form the inferior hypogastric plexuses on the sides of the hypogastric vessels and extend to the ganglion cells of Frankenhäuser's plexus close to the uterus and vagina. These fibers of the hypogastric plexus are supposedly preganglionic, forming synapses in the small peripheral ganglia of the ovarian hilus and parametrium. In addition to these main conceded nerve supplies there are other sympathetic nerve connections via fibers that accompany somatic nerves and blood vessels to become an important factor in the mechanism of pelvic pain.

From the nuclei of the second, third, and fourth sacral segments arises the parasympathetic nerve supply to the genital organs. This source supplies the detrusor muscle of the bladder, the colon, and the rectum. Another group of nerves from the same source contains vasodilator fibers to the external genitalia via the nervi erigentes. Langley and Andersen[2] claim that there is no parasympathetic nerve supply to the uterus and adnexa. Taylor[3] states that no certain observations appear to have been made to contradict this view. Since these autonomic nerves are involved in smooth muscle contraction and in vascular constriction and dilatation, they must be involved with fluid and electrolyte distribution in the tissues of the pelvic organs. While Langley[4] insists that the autonomic nervous system carries only efferent fibers, the success in many properly selected instances of presacral neurectomy

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must be due to the severing of afferent fibers of the autonomic nervous system.

The anterior abdominal wall is supplied by the iliohypogastric, ilioinguinal and genital branches of the genitofemoral nerve. The knowledge of the sensory nerve supply to the deep structures of the pelvis is still a little vague. The lateral walls of the pelvis derive their nerve supply from the obturator nerve, and the branches of the sacral and coccygeal plexuses supply the sacral and cardinal ligaments. With this somewhat superficial consideration of the anatomy and physiology, one may envision more clearly the possible mechanical factors involved in pelvic pain.

The character of the pain may be acute or chronic. The acute type resembles angiospasm or hypercontraction of muscle. The chronic pain suggests congestion. In a previous publication the author[5] has enumerated the characteristics of acute and chronic pelvic pain. They are as follows:

Characteristics of Acute Pelvic Pain

The symptoms may be:

1. Severe, colicky, indefinite, or generalized pelvic pain.
2. Associated with nausea and vomiting (a reflex symptom).
3. Associated with constipation or obstipation.
4. Symptoms of ectopic pregnancy, ruptured or leaking (peritoneal irritation).
5. Mittelschmerz with spotting.
6. Dysmenorrhea.
7. Dyspareunia.

Findings or physical signs:

1. Lower abdominal tenderness.
2. Rarely muscle spasm (except with peritoneal irritation).
3. If coinciding with ovulation, the findings are slight.
4. If associated with menstruation, the pain is often acute; and muscle spasm may be present, but is usually indefinite as to localization of the source.
5. Tender adnexa or uterus may be detected, especially tender uterosacral ligaments.
6. Replacement of a retrodisplaced uterus may give relief.

Crawford, *et al.*,[6] in discussing acute lower abdominal emergencies, referred to the conventional triad of pain, nausea, and vomiting. They reported the surgical emergencies at Roosevelt Hospital from 1940 to 1951 as due to:

1. Acute appendicitis.
2. Acute diverticulitis.
3. Intestinal obstruction.
4. Traumatic injuries to the abdomen.
5. Ruptured corpus haemorrhagicum.
6. Acute ulcerative colitis.
7. Ruptured ectopic pregnancy.
8. Torsion of ovarian cyst.
9. Acute salpingitis.
10. Endometriosis.

To this list should be added pelvic lymphadenitis, ruptured peptic ulcer and urinary calculus.

They further named as medical conditions that simulate surgical conditions of the abdomen as:

1. Diabetes mellitus.
2. Uremia.
3. Addison's disease.
4. Acute congestive failure.
5. Coronary thrombosis.
6. Pericarditis.
7. Dissecting aneurysm.
8. Sickle cell anemia.
9. Leukemia.
10. Henoch's purpura.
11. Typhoid fever.
12. Measles.
13. Porphyria.
14. Pneumonia.
15. Serum sickness.
16. Black widow spider bite.
17. Tabes dorsalis.
18. Herpes zoster.
19. Intercostal neuralgia.

Drug addiction and cystitis should be added to this list.

Characteristics of Chronic Pelvic Pain

The symptoms:

1. Often aggravated by posture and relieved by changes of position—usually worse with long periods of standing but sometimes worse in the dorsal position.
2. Dyspareunia (more often confirmed after questioning than volunteered).
3. Associated with spastic or mucous colitis.
4. Dysuria is rarely the chief symptom but is fairly frequently an elicited associated symptom.

Signs of Chronic Pelvic Pain

Because of the variation from identification of demonstrable pathology to absence of signs, the type of pelvic pain is usually classified according to the accredited etiology. The accredited etiology is based on the pathology demonstrated, and is classified as genital, extra genital, or, in the absence of demonstrable pathologic change, psychogenic in origin. Physicians should be cautious in explaining pelvic pain by existing pathologic evidence, but should be even more cautious in diagnosing neuroses in the absence of demonstrable pelvic pathologic conditions. The psychiatrist, possibly, should not be the last to be consulted, but he certainly should not be the first. The possibility of multiplicity of etiology should not be overlooked.

Findings in Patients with Pelvic Pain of Genital Origin

1. Tumors: (a) fibroids with pressure due to size, or pain due to necrosis (fibroids alone rarely cause pain); (b) ovarian cyst—twisted.
2. Endometriosis (worse at time of period).
3. Adenomyosis (dysmenorrhea appears late in menstrual life).
4. Chronic salpingitis (tender abdomen with congestion and peritoneal irritation).
5. Uterine displacements.
6. Varicosities of genital organs.
7. Childbirth displacements.
8. Prolapse of ovary.
9. Parametritis.
10. Stimulation of cervix by (a) chemicals, (b) dilatation, (c) cervicitis, and (d) ectropion.
11. General engorgement and tenderness with dysmenorrhea.
12. Dyspareunia (by history, vascular and congestive findings and change of mobility).

All are associated with pelvic congestion and probably vascular physiology.

Extragenital Origins

1. Pelvic varicosities.
2. Endocrine imbalance demonstrated by
   (a) relief with inhibition of ovulation, and
   (b) hypothyroidism.
3. Allergies (vascular physiology), "metrallergy" of Goodall and Power.[7]
4. Joint relaxations.
5. Diverticulitis.
6. Appendicitis.
7. Systemic: (a) tuberculosis; (b) Hodgkin's disease; (c) Addison's disease; (d) diabetes; (e) cardiorenal.
8. Anemias.
9. General debilitation (hypoproteinemia).
10. Rarely with blood dyscrasias.
11. Drug addiction.
12. Rarely with pelvic tumors (symptoms are pressure rather than pain).

Also, these all present the symptoms and findings of pelvic congestion and probably vascular physiology.

Psychogenic Origin

1. Acute shock.
2. Chronic emotional imbalance.
3. Absence of demonstrable pathology.

The fact that the pelvic and vascular system is highly responsive to states of mind is rather convincingly shown by an experiment reported by Duncan and Taylor.[8] Using a method dependent upon changes in thermal conductance, they showed that variation in pelvic blood flow took place whenever, during a psychiatric interview, subjects were touched upon toward which the patient had special emotional attitudes. It is hard to prove, however, that arteriospasm or dilatation does not exist, perhaps coincidentally.

Pelvic pain usually occurs between the ages of 20 to 40, which is the age period of the greatest reproductive and sexual activity. Rarely is the clinical picture noted after the menopause. The occasional finding of tender postmenopausal uterosacral ligaments is hard to explain on a vascular congestive basis, and it may be an example of the congestive fibrosis syndrome.

The vascular congestive theory of pelvic pain is not new. Schultz[9] in 1875 and Freund[10] in 1885 implied an infectious or at least an inflammatory cause by their term "chronic parametritis." Cotte and Dechaume[11] used the term "congestion pelvienne" in 1931; although Gooch,[12] according to Taylor,[13] suggested the idea of "pelvic congestion" in 1831. Opitz[14] and Martius[15] blamed spastic smooth muscle for uterosacral ligament tenderness. Young[16] in 1932 used the term "broad ligament neuritis." One cannot help but feel that these and other slightly dif-

ferent designations, including the "pelvic sympathetic syndrome" of Theobald[17] are tags for the same syndrome.

Consider the hypersecretion of a swollen cyanotic eroded cervix, with or without laceration, or when at celiotomy one encounters the soft, cyanotic, non-gravid uterus with an excess amount of amber colored fluid in the cul-de-sac. The term "pelvic congestion" seems appropriate. Also well known is the example of the eroded posterior lip in a patient with a retrodisplaced uterus. The erosion will recur after cauterization but will often clear up without local treatment if the retrodisplacement of the congested uterus is corrected. One can further theorize that prolonged congestion may cause fibrous tissue stimulation resulting in, for example, the bulky, hypertrophied hard or cyanotic cervix, or the so-called fibrocystic ovary. This congestive fibrosis syndrome, however, is still only theory.

Cohen and his associates[18] seem practically alone in their belief that pelvic discomfort may be manifestations entirely psychiatric in origin and hysterical in character without somatic components, that the pain is imaginary and exists only in the patient's mind. The pelvic vascular experiments during psychiatric interviews by Duncan and Taylor[8] seem to refute this belief and point to pelvic vascular physiology.

So-called primary dysmenorrhea, which is diagnosed in the absence of demonstrable pathology, has been frequently discussed, but never satisfactorily proved to be entirely sytemic, psychogenic, or hormonal in origin. Known, however, are certain characteristics of the pattern behavior of primary dysmenorrhea. These characteristics are that it:

1. Usually begins shortly after menstruation is established.
2. Tends to be crampy in character and is associated with constitutional symptoms.
3. Seldom, if ever, occurs in the absence of ovulation.
4. Is often accompanied by underdevelopment of the genital organs.
5. Is diagnosed in the absence of recognizable pelvic pathologic change.
6. Usually disappears gradually after childbirth.
7. Is often associated with hypothyroidism.
8. Often occurs in emotionally unstable persons.

Hyperactive uterine muscle contractions and arterial spasms are generally offered as the explanation, and psychogenic and hormonal origins have been most often advocated for primary dysmenorrhea. A theory of a menstrual toxin has been presented by Smith and Smith.[19] This is similar to the "necrosin" described by Menkin.[20] Markee[21] points out that rapid regression of endometrium initiates the chain of events leading to menstrual bleeding, that this depends upon the pituitary, ovarian endometrial relationship and that any interference with this relationship causes menstrual disturbance. The economic, social, and psychiatric aspects have been considered by Miller and Behrman.[22]

Kimbrough[23] stated that he has "never seen crippling dysmenorrhea of the primary type in a girl who is well adjusted emotionally". These factors seem to be aggravating or contributing rather than the principal etiologic factors. More simply it can be stated that with the onset of bleeding the pain of dysmenorrhea diminishes.

The author is inclined to agree with Taylor[13] who has presented as evidence that the local vascular condition is the dominant feature of pelvic pain. He presents as evidence of this belief:

1. The anatomic and mechanical factors resulting in change of pelvic intravenous pressure due to posture or faulty support.
2. Hormones, especially estrogens, cause hyperemia and increase tissue fluid in the hormone-controlled organs.
3. The presence of complicating inflammation can at least cause local hyperemia or congestion.
4. The sympathetic and parasympathetic nerves to the pelvis can cause vasodilatation and vasoconstriction.

As additional support of the vascular congestive theory, it would seem more than coincidental that the severity of symptoms parallels the vascular changes. The symptoms are most severe during the premenstrual period when abnormal congestion is added to physiologic hyperemia, and subside with the shedding of the endometrium and bleeding with the resulting relief of congestion. Pelvic pain diminishes with the menopause with its decreased vascularity. Pain is often worse after coitus with its probable vascular hyperemia. Pain, aggravated by pro-

longed standing, is relieved by the recumbent position but often only by change of posture with its relief of venostasis.

Management of Pelvic Pain

Certain rules govern the management and therapy for pelvic pain.

1. Decision on the origin—whether genital, extragenital or psychogenic.
2. Correction of the existing pathologic condition—whether by mechanical or medical measures, or by restoration of normal endocrine balance, or as a last resort by psychiatry or even by surgery.
3. Simplicity of therapy should be favored before resorting to surgical, psychiatric, or hormonal therapies.
4. The possibility of a multiplicity of etiology must be considered and the several possible etiologic components identified and appropriately treated.
5. Suppression of ovulation in real cases of primary dysmenorrhea.
6. Show a sincere willingness to consult specialists in fields other than gynecology when indicated.

If one accepts the evidence as presented to substantiate the theory of "pelvic congestion" on a basis of vascular physiology, it would seem proper to classify the therapies for the pelvic autonomic syndrome as nonoperative, gynecologic, or surgical with consideration of the psychiatric factor. Since the psychiatric factor is so often a contributing or aggravating factor rather than a primary one, perhaps it should be considered first.

The psychiatric factor of therapy consists primarily of reassurance by the physician of his sincere sympathy, yet his lack of concern as to any serious nature of the patient's condition. By this means he allays the patient's existing fear (whether expressed or not) of infertility, cancer, infection, or the possibility of an operation in the future. The explanation that the disorder is functional rather than organic, but certainly not imaginary, will alleviate the probability of discouragement if the symptoms return; and the patient should be warned of this possibility. A review by the gynecologist of social, sexual, business, and family dissatisfaction will often elicit the key factors of the tension.

Alertness of the gynecologist to seek psychiatric help for associated mental illnesses before rather than after resorting to surgery will eliminate a fair number of previously advocated unsuccessful operative procedures, and their resulting unhappiness for the surgeon as well as for the patient.

Nonoperative Therapy

1. Rest (postural-physical and sexual) is in keeping with the vascular congestive theory of pelvic pain.
2. Correction of relaxation of the pelvic supports with pessaries. If successful, a more permanent relief may be accomplished by proper plastic repair in keeping with the patient's reproductive plan.
3. Correction of infection, especially of cervix, adnexa and parametria.
4. Hormonal therapy. Androgens reduce temporarily the pelvic congestion caused by estrogens. The elimination of pain at menopause may in some patients be accomplished by completing the menopause with radium.

All of these therapies are aimed at the devascularization of the pelvic structures.

Surgical Therapy

1. Hysteropexy.
2. Complete hysterectomy.
3. Partial or unilateral oophorectomy.
4. Presacral neurectomy.
5. Uterosacral ligament section.

In spite of abuse in the past, all of these procedures in properly selected patients are in many instances successful, but should not be advised until the relatively simple nonoperative weapons have been exhausted.

Conclusions

Apparently most pelvic pain results from some form of pelvic congestion, localized or general, and its localization is accomplished by the so-called visceromotor reflexes. These impulses are thought to be initiated by disturbances of pelvic vascular physiology. Pelvic pain is usually classified by the acute or chronic nature of the pain, and by the associated pathologic condition detected. It may be considered as genital, extragenital, or, in the absence of demonstrable pathology, as psychogenic in origin. While the possibility of contributing factors cannot be discarded, one origin usually predominates.

The management of pelvic pain should consist in simplicity of therapy before resorting to surgical, hormonal, or psychiatric methods, and, if a multiplicity of etiology is

recognized, appropriate therapy for each etiologic component should be employed.

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AMPHOTERICIN B IS AN EFFECTIVE AND PRACTICAL DRUG for the treatment of cryptococcal meningitis when administered early enough in the course of this illness. In three case histories no untoward reaction of significance to amphotericin B was observed when this drug was prepared and administered as directed by the manufacturer, although acute side reactions, including shaking chills with fever, may be noted on occasion with the initial infusion. Such acute side reactions can be minimized or eliminated by premedication with acetylsalicylic acid or an antihistamine preparation. In its present form, amphotericin B must be adequately diluted in water (1 mg./10 ml.) and given by slow intravenous drip over a span of several hours. Any attempt to hasten the transfusion will result in a pyrogenic reaction and a local chemical thrombophlebitis. Total daily dosage should be increased gradually up to 1 mg./kg. Transient elevation of the blood urea nitrogen has been observed with higher doses of amphotericin B, but no significant toxic changes in the hematopoietic, hepatic, renal, cutaneous, or nervous systems have been noted in the patients treated thus far. The optimal dosage and duration of amphotericin B therapy for human central nervous system cryptococcosis has not been established. *In vitro* studies have demonstrated that the minimal inhibitory concentration of amphotericin B for C. neoformans is a fraction of 1 μg./ml. of broth. Blood level determinations have shown that adequate fungicidal concentrations of amphotericin B have been attained and maintained for as long as 18 hours with the regimen of intravenous therapy employed by the authors; infusion of the drug on alternate days is possible if a higher dosage is being given. Cerebrospinal fluid levels of amphotericin B following intravenous administration of this drug have not been consistently demonstrable by the bio-assay technique suggested by Litterman. Following intrathecal drug administration, detectable cerebrospinal fluid levels have persisted up to 48 hours. However, the recovery of patients without the intrathecal administration of this drug suggests that adequate fungicidal drug levels were reached in the cerebrospinal fluid following intravenous administration, even though present methods of detection by bio-assay could not demonstrate their presence.—Fitzpatrick, Martin J., Rubin, Harry, Poser, Charles M.: The Treatment of Cryptococcal Meningitis with Amphotericin B, a New Fungicidal Agent, Ann. Internal Med. 49:249–259 (August) 1958.

Surgical Indications in Nontoxic Nodular Goiter; a Controversial Problem*

By CARL W. EBERBACH, M. D.**

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FOR SEVERAL DECADES, a changing picture in diseases of the thyroid gland has been a stimulating challenge to both the surgeon and internist. In order to intelligently appraise the subject under discussion, it is important to project it against a background of past experience in various types of institutions as well as in geographic locations.

After reviewing many scientific papers published recently—in an attempt to discover our present thinking in the management of nontoxic nodular goiter—I have gained the impression that there is no general agreement. Most authors at some point in their discussion variously describe our interpretation of the problem as "controversial", "a bewildering mass of information", "heated debate", or "running fight". Much of this confusion may result from data based on selected cases. The picture will vary greatly in private, charity, and cancer hospitals.

In an attempt to secure a true cross section of thyroid disease not exposed to institutional selection in an endemic goiter area, an analysis of 4,885 thyroidectomies in private patients is presented. These patients were operated upon during the period 1920 to 1958 for thyroid pathology. This report includes the results of surgical procedures done by three associates.

Until 1940, the dominating thyroid lesion in our experience was hyperthyroidism (fig. 1), when suddenly there occurred a drop in the number of toxic goiter patients requiring surgery. Whether this was due to the common use of iodinized salt, the widespread sources of food used in this area, or the use of antithyroid drugs, is difficult to interpret. We may be witnessing the passing of a goiter belt. As a result, the nontoxic nodular goiter has become relatively more common and is now attracting increasing attention.

The indications for thyroidectomy in nontoxic nodular goiter have changed importantly during the past ten years. While pressure symptoms and cosmetic factors are still important indications for thyroidectomy, the reported high incidence of cancer in these glands has stimulated two schools of thought. One group of surgeons insists that all nodular goiters should be removed, and a second group feels that experience and selection on the basis of certain criteria should be the guiding factor. Before accepting either view, it is important to develop a realistic evaluation of the problem.

Interest in nontoxic nodular goiter was importantly stimulated by the observations of Cole and associates,[1] reported in 1945. In a series of 192 nontoxic nodular goiters, a cancer incidence of 17.2% was recorded. On further analysis of these cases, cancer was found in 24% of solitary nodules and 11% of multinodular glands. Many studies have

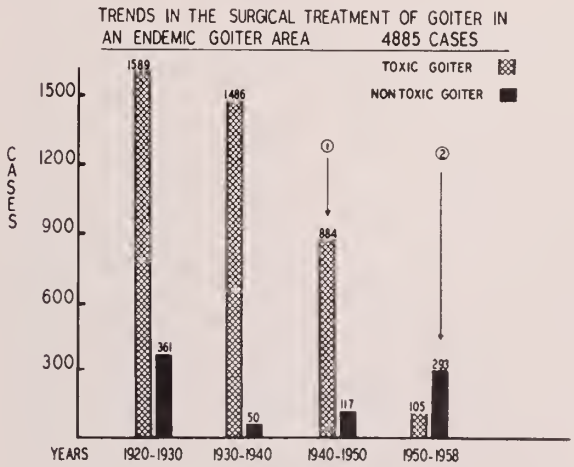

Fig. 1—(1) Decrease in thyroidectomy for toxic goiter reflects the use of antithyroid drugs, I^{131} and decrease in the incidence of the disease. (2) The impact of emphasis on malignancy in nontoxic goiter is seen here.

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been reported since then, most of which support these findings, the incidence varying from approximately 3% to 17% in multinodular, and 4% to 33% in solitary nodular surgically removed glands. These findings apply to children as well as adults. Cohen and Hyman[2] found that the cancer incidence reported in the literature varied from 19% to 52% in children with nontoxic nodular goiter.

In our experience from 1930 to 1957, there were 62 cases of cancer in 522 nontoxic nodular goiters (460 benign, 62 malignant), or approximately 12%. These statistics might be disturbing indeed, if we fail to realize that they are the result of carefully selected cases. Compared with other types of cancer, however, this lesion is relatively rare. Vital statistics in Wisconsin show that of the cancer deaths in 1956, only 0.51% were due to thyroid cancer as compared with 17.5% for large bowel and rectum, 10.9% for stomach, and 9.25% for cancer of the breast.

Many other observations tend to show that cancer is relatively rare in nontoxic nodular goiter in an endemic goiter area. In a review of the records of 200 consecutive admissions to the medical department of Milwaukee Hospital for diseases not related to the gland, 8% (2% male and 6% female) were found to have nontoxic nodular goiter, and 4% diffuse enlargement. These patients varied in age from 11 to 83 years; 44% were male and 56% female. This series of cases is too small to be significant, but emphasizes the high incidence of benign nodular goiter. More extensive studies have been made by others. Perlmutter and Slater[3] found asymptomatic nodular goiter in 4% of 1,000 cases, both male and female between the ages of 30 and 60 years. They quote Vander and associates[4] who found a 4% incidence of these lesions in a study of over 5,000 cases in a non-goitrous area (Massachusetts). Crile and Dempsey[5] found asymptomatic nodular goiter in 4% of all admissions to the Cleveland Clinic, and Miller[6] reported 11.2% in the female population at Henry Ford Hospital. As a result of his studies, Perlmutter concludes that the probable incidence of cancer in unselected cases of nontoxic nodular goiter is 2%. In the light of these findings, it seems wise to continue the widely accepted practice of careful selection of asymptomatic nodular goiters for thyroidectomy. It is true that at the hands of competent surgeons the risk is not great. Sokal,[7] however, in a

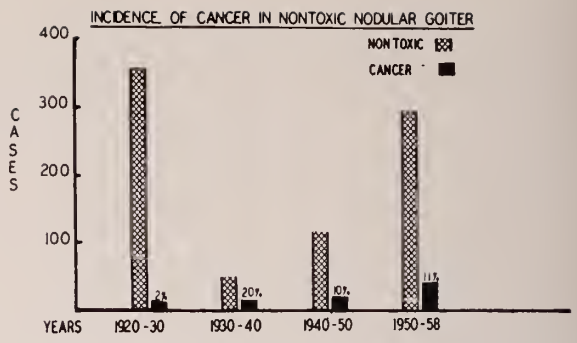

Fig. 2—The cancer incidence recorded by decades in 890 thyroidectomies for nontoxic goiter is shown here.

thoroughgoing study of the incidence of cancer in a non-goitrous area, emphasized the danger of routine extirpation of all nontoxic nodular goiters, pointing out that the mortality and morbidity would outweigh the additional cures.

The impact of the changing pattern of thyroid disease in this endemic goiter area, plus the emphasis on malignancy at this time, is illustrated in a statistical study of our thyroidectomies for nontoxic nodular goiter (fig. 2). The dominating lesion has now become nontoxic thyroid disease. During the decade 1940–1950, cancer was suspected in only about 20% of patients. Since 1950, a preoperative suspicion of cancer was recorded in 50% of cases, but the incidence remained the same. An analysis of the pathologic changes in nontoxic nodular goiter since 1950 is seen in table 1. These, too, have remained the same over the years.

Table 1.—Nontoxic Nodular Goiter

An analysis of 329 cases operated upon—1950 to 1958

Type	Benign 293	Malignant 36 (11%)
Age	8 to 73 years	22%—40 yrs. or under
Sex	Female 87.6%	Male 12.4%
Pathology	**Benign**	
	Adenoma—Follicular, embryonal, colloid, etc.	254
	Papillary cystadenoma	2
	Hürthle cell	5
	Thyroiditis	32
	Malignant	
	Papillary and follicular adenocarcinoma	22 (61%)
	Undifferentiated	13 } (39%)
	Sarcoma	1 }

Indications for Surgery

In nontoxic nodular goiter with pressure symptoms or disfigurement of the neck, there is no problem. Their removal will improve the patient's health and well-being. In asymptomatic nodular goiter, however, we

are confronted with a difficult decision because of the possibility of malignant disease. Unfortunately, there is no known means of accurate diagnosis of thyroid cancer except by microscopic study. Needle biopsy is contraindicated because of the implantation of cancer cells into normal tissue, in addition to being of little value if a negative specimen is obtained. Isotope studies (I^{131}) have gained some diagnostic importance since malignant lesions retain little, if any, I^{131}. These so-called "cold" nodules have been found to be malignant in about one-third of the cases studied. Johnson and Beierwaltes[8] reported 31% proven cancer in their series. Miller and associates[9] point out that scintigrams are unreliable if the suspected nodule is less than 2 cm. in diameter, and in patients past 40 years of age, because of colloid and calcified nodules with low uptake.

Since there is no pathognomonic sign of early thyroid cancer, we are compelled to select cases for operation on the basis of suspicious changes in the gland and sound judgment. In the undifferentiated types of cancer which occur most commonly after 40 years of age, the clinical diagnosis is generally made preoperatively, based on a finding of hard, indurating, rapidly infiltrating, fixed new growths in one or both thyroid lobes with hoarseness in the later stages. The prognosis is usually hopeless.

In the more highly differentiated types, which may grow slowly for many years, various signs are suggestive. Because of the relatively high cancer incidence in clinically solitary nodules, these are significant. Any suspicious nodule showing recent growth, irregularity, or unusual hardness must be considered potentially malignant. The existence of a nodule for several years does not rule out cancer.

In about 20% of his cases, Crile found an average duration of three years before diagnosis. Shallow[10] reported a delay of 5 years or more in 23%, and at the Mayo Clinic, in a large series of cases, Beahrs and Judd[11] found that a goiter or enlarged cervical lymph nodes were present for 5 years or more in 40% of patients before cancer was suspected. So-called "aberrant" nodules in the triangles of the neck, now recognized as metastases to cervical lymph nodes, may occur before the primary lesion is recognized. In our experience, these have been recorded in less than one-third of the cases. Frazell and Foote (Memorial Center for Cancer),[12] however, have observed in a series of 182 cases of papillary cancer, that a clinical diagnosis of cervical nodes with metastases was made in about 60% of the cases. There was an additional 61% incidence of metastases in those not clinically recognized. A search for these nodes, therefore, is important and a definite indication for resection. In children, the percentage of cancer in asymptomatic nodular goiter is higher than in adults passed the age of 40, with the papillary and alveolar types predominating. Hayles and associates[13] at the Mayo Clinic, reported a series of 41 cancers in children under the age of 15 years, all of which were follicular or papillary types. Thyroidectomy is clearly indicated in most of these cases.

Cancer Classification and Behavior

In general, thyroid cancer is classified under three headings.

1. Highly differentiated papillary, follicular, or alveolar adenocarcinoma.
2. Undifferentiated cancer, including small and giant cell types.
3. Rare types not originating in thyroid cells as squamous cell carcinoma and sarcoma.

Groups 2 and 3 constitute about 40% of thyroid cancers. These are generally diagnosed as malignant disease before operation and the prognosis is poor. Most of them occur after the age of 40. The highly differentiated types of thyroid cancer (group 1), on the other hand, behave quite differently. These cannot be accurately diagnosed before operation. In fact, many of them are not

Table 2.—Thyroid Carcinoma

Observations in 62 cases operated upon from 1930 to 1956

Path. Diagnosis	No. of cases	% of total	Died	% of deaths	*Alive 2 or more years postop.	% survivals
Papillary and follicular adenocarcinoma	39	63	**4	10.0	35	90.0
Undifferentiated adenocarcinoma	18	29	12	66.6	6	33.3
Sarcoma	2		2	100.0	0	
Squamous cell carcinoma	1	8	1	100.0	0	
Advanced carcinoma operated upon elsewhere	2		2	100.0	0	
Total	62	100	21		41	

* 21 of these patients are known to have lived 5 years or more postoperatively without recurrence.

** One of these patients was killed in an auto accident, and a second died of coronary disease, both without recurrence after 2 years.

recognized until discovered by the pathologist. They are slow growing, metastasize slowly, and with proper surgical treatment carry a good prognosis with 85% to 95% five-year survivals. Our experience with the various types of thyroid cancer is shown in table 2. These observations are not unlike those recorded in the literature.

Treatment

All patients with nodular asymptomatic goiter are advised to have periodic observations whether operated upon or not.

In the undifferentiated cancers, radical excision of the thyroid gland and lymph nodes of the neck is desirable when possible, but in our experience and in that of others, this is rare. X-ray irradiation is of palliative value, but I^{131} is entirely worthless.

In the management of the differentiated types of cancer, there are again two schools of thought. One favors radical resection routinely; and the second, total resection of the involved lobe and isthmus, with removal of palpable regional lymph nodes. Crile[14, 15] has repeatedly emphasized the latter procedure, and has supported his opinion with operative results and with the observations that the accepted en bloc resection of the lymphatics of the neck is entirely inadequate as a radical procedure. He also emphasizes the importance of protection of the thyroid gland against injury by sharp instruments because of the dangers of spread and implantation. In our experience, we have followed a similar plan for many years with the results shown in table 2. The radical resection has been used only in postoperative recurrent lesions, or in those patients with multiple palpable lymph nodes with metastases. It is interesting that in a review of 160 cases of thyroid cancer at the Lahey Clinic where en bloc resection was done as a rule in the papillary and follicular types of cancer, Meissner and his associates[16] stated that the study does not prove the desirability or inadvisability of radical neck dissection of thyroid cancer. Though it is impossible to predict the behavior of any given cancer, most of the papillary and follicular types remain local and metastasize slowly over periods of five to ten years, allowing abundant opportunity for further surgical procedures if necessary. It is unwise, therefore, to be-

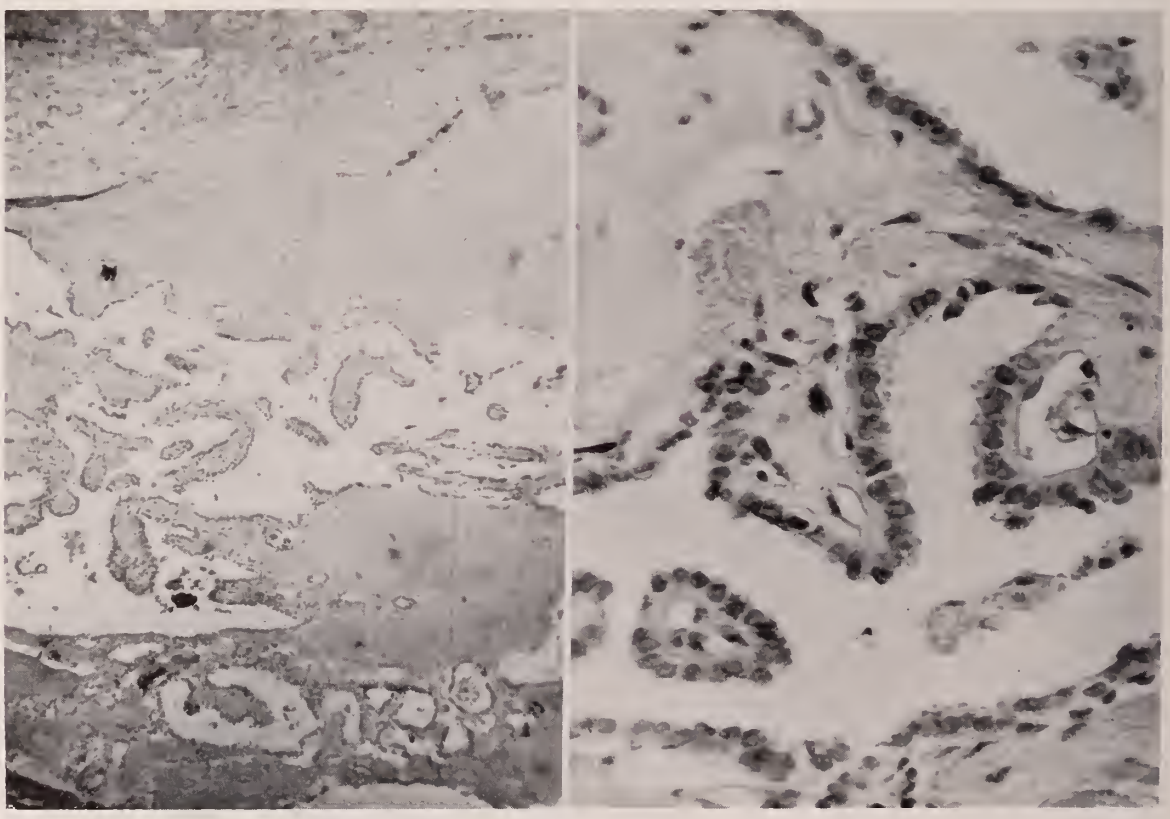

Fig. 3—Sections of thyroid gland with papillary carcinoma after treatment with 75 mc. of I^{131}. Note complete destruction of normal gland (left) and failure to destroy cancer cells (right).

come dogmatic about any method of treatment.

Postoperative x-ray irradiation in the highly differentiated cancer of the thyroid gland is effective, but I^{131} is of little value except in the so-called metastasizing adenoma. In one patient, referred after a biopsy was done for an "aberrant" thyroid nodule, 75 mc. of I^{131} were administered over a period of three months, after which total lobectomy on the side of the metastasis as well as removal of the isthmus was done. A microscopic study of the thyroid gland showed complete destruction of normal thyroid tissue with no effect whatever on the cancer (fig. 3). We have used it in only 6 cases, but without effect. Similar observations have been made by others in larger series.

Attempts to activate the cancer cells with total thyroidectomy, antithyroid drugs and thyroid stimulating hormone with the hope of increasing their avidity for I^{131} have not been successful. On the contrary, hormonal therapy in the form of desiccated thyroid gland, which is used to combat postoperative hypothyroidism, is more likely to be effective in the control of cancer growth, since it depresses the pituitary gland, reduces the thyroid stimulating hormone, and avoids stimulation of any remaining metastatic cancer cells which may be hormone dependent. Increasing studies on hormonal control of certain types of thyroid cancer are being reported. Thomas,[17] Crile.[18]

The following case will illustrate some of the frustrations encountered in the diagnosis and treatment of thyroid cancer.

Case 1. On November 15, 1941, a 55-year-old, obese, hypertensive white female gave a history of having had a goiter on the right side of the neck for 28 years. A month before admission a second swelling appeared lateral to the primary tumor just above the clavicle. At operation a large (9x7x4 cm.), soft, nodular, encapsulated tumor was shelled out of the right thyroid lobe, leaving a small amount of thyroid tissue. One centimeter to the right and extending below the clavicle, a second soft, grossly colloid type of "accessory thyroid" (2x3 cm.) was easily shelled out from the surrounding tissues. The left thyroid lobe was small and normal.

The pathologic diagnosis was "multiple cystic, calcareous, colloid, and fetal adenomata with some areas of hyperplasia". Two years later, (February 1943) recurrence of the tumor was observed and removal attempted. Infiltration locally and down the jugular vein to the subclavian vein made complete removal impossible. A diagnosis of papillary adenocarcinoma was then made. Rapid and excellent palliative response to x-ray followed. In February, 1947, x-ray failed to control the growth. Palliative resection to free the trachea was done. There were no distant metastases demonstrable. Chest x-ray was normal.

During the next year, increasing nervousness was observed, and basal metabolism studies were reported as plus 26 and plus 34. Isotope studies, however, showed no significant uptake in the cancer area. Symptomatically the patient improved under Lugol's solution. Her obesity and hypertension persisted. She died suddenly at home in September, 1950, of tracheal and mediastinal infiltration.

This case emphasizes the unpredictable behavior of papillary adenocarcinoma. The presence of goiter for many years does not rule out cancer. Diagnosis may be difficult and missed at the outset by a competent pathologist. With the absence of distant metastasis over a period of nine years, the importance of local resection is emphasized. This patient, as is frequently seen, died of local tracheal and mediastinal invasion. Had a total thyroidectomy and careful resection of the local lymphatic chains been done at the outset, the ultimate result might have been more favorable. X-ray therapy has demonstrated its value by giving marked palliative relief. The neutralization of thyroid stimulating hormone with Lugol's solution, with resulting temporary improvement, supports the belief that pituitary depression with desiccated thyroid is of value in controlling metastatic thyroid cancer of the papillary type.

Summary and Conclusions

The medical and surgical literature during the past 15 years tends to distort the true picture of thyroid pathology because of a high degree of selection of cases in various types of institutions reporting them. An analysis of a series of 4,885 private patients, not influenced by institutional selection, is analyzed in an attempt to establish a true cross section of the rapidly changing goiter problem in the Great Lakes' goiter belt. We may be experiencing the passing of an endemic goiter area. Until the early 1940s, the dominating indication for surgery was toxic goiter; only about 12% of thyroidectomies were done for nontoxic nodular goiter. From 1950 to 1958, about 73% of the goiters operated upon were classified as nontoxic types. In our experience, since there is an 11% incidence of cancer in nontoxic nodular goiter, and since the medical litera-

ture records an incidence varying from 5% to 30%, the problem becomes disturbing.

We are confronted with two schools of thought in the management of nontoxic nodular goiter. (1) Thyroidectomy in all cases. (2) Selection of cases. There is general agreement that large nodular goiters should be removed because of pressure symptoms and for cosmetic reasons. It is also generally agreed that the high incidence of papillary and follicular cancer in asymptomatic nodular goiter in children under the age of 15 years demands thyroidectomy. Routine thyroidectomy in nodular goiter in adults in an endemic goiter area, however, would lead to many unnecessary operations.

Cancer of the thyroid is a relatively rare disease. Only .5% of deaths from all cancer results from cancer of the thyroid as compared with 17.2% from colon and rectum, 10.9% from stomach, and 9.25% from breast cancer. Furthermore, in this area about 2% of the male and 6% of the female population have asymptomatic nodular goiters. These observations favor selection of cases for operation based on the appearance of a solitary nodule, a rapid lobular increase in size of a goiter, hard irregular nodules, palpable cervical lymph nodes, and any other suspicious changes in the gland.

Having diagnosed thyroid cancer, there are again two schools of thought regarding the treatment of the papillary and follicular types. (1) Routine en bloc resection. (2) Total lobectomy and removal of the involved lymph nodes with many variations depending upon the extent of the lesion. Since the standard en bloc resection is inadequate as a radical procedure for removing all local and regional lymphatics, its advocates tend to admit that its use as a routine procedure is questionable. Most thyroid surgeons, however, use it when extensive regional metastases are present and in recurrent disease.

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Booklet Revised on Diagnosis of Congenital Cardiac Defects

A thoroughly revised and expanded edition of the Heart Association's booklet "Diagnosis of Congenital Cardiac Defects in General Practice," by Dr. Regina Gluck, is now available to physicians free of charge through the Wisconsin Heart Association, 205 West Highland Avenue, Milwaukee, 3, Wisconsin.

Designed primarily for general practitioners and pediatricians, the booklet is intended to clarify the function of the family physician in diagnosing and referring patients with congenital cardiac defects. It describes common congenital cardiac defects and presents briefly the physiology and clinical findings and the indications for surgery in defects that may be operable.

The Management of the Complicated Duodenal Ulcer*

By JOSEPH SHAIKEN, M. D.**

Milwaukee, Wisconsin

EIGHTY TO EIGHTY-FIVE per cent of patients with duodenal ulcer respond well to medical treatment; the remaining 15% to 20% develop complications which may assume serious proportions.

Hemorrhage, obstruction, and perforation constitute duodenal ulcer complications which may occur singly but occasionally in combination.

The most common complication is hemorrhage, the most serious is perforation.

Hemorrhage

Hemorrhage occurs in about 10% of hospitalized patients with peptic ulcer. The patient with a hemorrhage is best treated in a hospital.[1]

Hemorrhage from ulcer may be classified in many ways. The most important division clinically is between the simple, easily controlled hemorrhage and the massive, exsanguinating hemorrhage. The modern management of hemorrhage from peptic ulcer may be said to date from the introduction of the prompt feeding program by Meulengracht in 1931, although Lennartz in 1904 and Andresen in 1927 had the same idea of treatment.

Careful clinical observation, estimation of the pulse and blood pressure, repeated blood determinations, prompt feeding, and judicious use of blood transfusions form the basis of the medical treatment of hemorrhage.

Early diagnosis of the cause of the hemorrhage is important. The fluoroscopic and roentgen study of the upper digestive tract is done within a few days depending on the condition of the patient.

Bromsulfalein determination to rule out cirrhosis of the liver with esophageal varices is performed early.

Esophagoscopy and gastroscopy are utilized in indicated patients.

In some hospitals a team consisting of an internist, a surgeon, a pathologist or laboratory representative, and a radiologist has gained acceptance in the management of the patient with hemorrhage. This combined effort in treatment is helpful, but one individual must correlate the findings and suggestions from the group and make the final decisions.[2]

The bleeding ulcer patient presents special problems when (1) the patient had stopped bleeding under treatment in the hospital and then starts bleeding again, (2) if the patient is in the older age group, (3) if pain is present in addition to the hemorrhage, (4) if the patient has a postbulbar duodenal ulcer,[3] and (5) if the patient has a massive hemorrhage and is in danger of exsanguination.

The decision as to when medical treatment has to be abandoned and surgical treatment instituted depends fundamentally on the rate of blood loss. If blood cannot be replaced fast enough to compensate for the blood lost, surgery has to be performed. The decision frequently has to be made in hours rather than days.

What is done at surgery is determined by many factors: the age of the patient, the patient's condition, and the ability of the surgeon.

The best surgical treatment for the bleeding ulcer patient is a subtotal gastrectomy; however, this is not always possible and occasionally less extensive surgery is performed.

Obstruction

Gastric retention due to transient obstruction is a common complication of duodenal ulcer.[1] It may be due to spasm, edema, or

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inflammation. When spasm, edema, or inflammation is present, medical measures are usually sufficient to relieve the obstruction. If cicatrization from the healing of an ulcer is the cause of the obstruction and if the resulting stenosis is marked, surgery will become necessary.

The medical treatment of gastric retention resulting from pyloric obstruction consists essentially of resting and decompressing the stomach by aspiration of the gastric contents, by giving fluids intravenously, withholding all food by mouth, and using antispasmodics by injection. The aspirations, carried out daily, are measured and charted. If the amount of the aspirated gastric contents becomes greatly decreased promptly, it becomes evident that the obstruction is subsiding.

If the gastric content does not show a rapid reduction in amount, it does not take long to decide that surgical intervention will become necessary. If doubt exists as to the degree of gastric retention, fluoroscopic and roentgen examination after the stomach has been emptied by tube will readily demonstrate the degree of pyloric obstruction at 6, 12, and 24 hour observations.

Pyloric obstruction does not present an emergency comparable to hemorrhage or perforation. There is more time for careful observation and evaluation.

In hemorrhage and perforation the passing hours are very important and decisions have to be made quickly. Obstruction does not usually represent this type of emergency. There is time for careful evaluation of the diagnosis and treatment.

If surgery is to be performed, a period of decompression is essential; fluid replacement is important; electrolyte balance must be maintained; and surgical treatment of choice is a subtotal gastrectomy.

Perforation

Acute free perforation is the most serious complication of duodenal ulcer. This complication is less frequent than either hemorrhage or obstruction. The immediate effect of a free perforation is very severe abdominal pain which may be followed by collapse. The abdomen usually becomes boardlike and rigid.

The treatment of choice is immediate closure of the perforation. Time is of great importance. In the past, simple closure was the treatment; today, in the younger patient, subtotal gastrectomy has been done with good results.

Recently and particularly in England a nonoperative treatment for perforated ulcer has been used. The treatment consists of the use of parenteral fluids, gastric aspirations, the use of antibiotics, and careful clinical observation.[2]

This type of treatment should be reserved for the perforations that have occurred many hours before or in the patient who is in very poor condition and in whom surgery would entail a very serious risk.[2]

The term perforated ulcer is generally applied to an anterior wall gastric or duodenal ulcer which has ruptured into the free peritoneal cavity. Ulcers located on the posterior wall of either the stomach or duodenum rarely perforate into the free peritoneal cavity. The ulcer may erode the wall of the stomach or duodenum and invade the underlying structures. The base of the ulcer is actually formed by the underlying organ, most frequently the pancreas or liver. This type of ulcer is known as a "perforated walled-off ulcer,"[4] or the confined perforation.[5] The fact that this type of ulcer constitutes the greatest number of intractable peptic ulcers deserves emphasis.[6]

The most significant feature of the perforated walled-off ulcer is a change in the ulcer pattern. The ulcer pain becomes more sharply localized in the epigastrium, more severe, and frequently requires opiates for relief. The pain becomes deep and boring in character and may become constant.[4]

The pain usually radiates to the back, but may radiate upward over the anterior chest wall or downward over the lower abdomen.

These patients must be hospitalized and treated intensively medically. Opiates are frequently required to control pain. The patient does not usually respond to a medical regimen and surgical treatment becomes necessary.

Prevention

More important than actual treatment of the complications is their prevention.

The prevention of these complications starts with the realization that duodenal ulcer is a disease that lasts a lifetime. Therefore intensive, continuous, complete treatment is the very basis of management.

The patient must be treated as a complete person with instructions not only as to diet and medications but also he must be advised

to avoid tobacco, alcohol, and coffee. He must be instructed regarding the injurious effects of the salicylates, steroid hormones, and other antirheumatic drugs. The basic tensions of the home and at work must be carefully evaluated. The patient must be kept under continuous treatment with periodic clinical and roentgen studies to determine the progress of treatment. Adherence to the diet is stressed.

The patient is encouraged to follow a good routine in work and rest. He must be taught to anticipate recurrences and to take special precautions if a respiratory infection occurs or when there is undue tension at home or at work. The medications may have to be changed or increased in amount.

This program of managing the patient with a duodenal ulcer has proved to be sound. It does not prevent ulcer recurrences or complications. In the cooperative patient it helps to cut down on the number of recurrences and may prevent complications.

I agree entirely with Bockus: "Recurrences may be mild and brief and complications frequently prevented (1) if the patient is carefully indoctrinated concerning methods that stand the greatest chance of preventing recurrences, and (2) if rigid therapy is instituted at once with the reappearance of the very first sign of recurrence."[5]

Summary

The complications of hemorrhage, obstruction, and perforation occur in patients who have the most severe type of duodenal ulcer. These are the patients that require the best ulcer treatment.

Complete, continuous, supervised treatment is of utmost importance. The patient must be taught to anticipate and to treat a recurrence of ulcer activity immediately and thoroughly. It is the only method now available to treat ulcer recurrences and to keep complications at a minimum.

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STUDIES OF THE PROBLEM OF REFRACTORINESS to oral intrinsic factor-vitamin B_{12} preparations as seen in some patients with pernicious anemia (PA) indicate that only certain amounts of intrinsic factor (IF) can be blocked by whatever inhibitory capacity exists in these patients. By the administration of massive doses of IF (500 mg.) in 16 refractory PA cases, refractoriness was broken and normal responses were obtained, as measured by the Schilling test. In 5 or 6 cases which were refractory also to human gastric juice in the standard amount (50 mg.), excretion of radioactivity was within the normal range when the Schilling test was performed using a fourfold dose (200 mg.). Oral refractoriness in PA may be quantitative rather than qualitative in nature. A previously suggested absolute blocking effect on the heterologous IF is not present in the intestine. The Ouchterlony agar diffusion technique failed to demonstrate antibody precipitation of IF in serum or duodenal juice from refractory PA patients. It seems possible that refractoriness to the newer oral preparations could be due to the fact that these contain lesser amounts of IF than did the older oral preparations, to which refractoriness was rarely, if ever, observed. It remains to be seen whether or not refractory patients can be treated successfully with greatly increased amounts of IF together with vitamin B_{12}, and whether or not future refractoriness to the increased dosages of IF will develop.—Berlin, Ragnar; Berlin, Hans; Brante, Gunnar; Sjoberg, Sven-Gosta: Refractoriness to Intrinsic-Factor-B_{12} Preparations Abolished by Massive Doses of Intrinsic Factor, Acta Med. Scandinav. 162:317–319 (Nov. 10) 1958.

New Telephone Number for Milwaukee Poison Center

To contact the Milwaukee Poison Center, call the new number which is DIvision 4–7100. A detailed report on Poison Control in Wisconsin was published in the February issue of the *Wisconsin Medical Journal* and it carried the old number.

The Poison Information Center in Milwaukee was established in 1956 through the efforts of The Medical Society of Milwaukee County Subcommittee on Accident Prevention. This poison information service is available to all Milwaukee area physicians at DI 4–7100 (Milwaukee Children's Hospital) 24-hours a day.

Five hospitals act as treatment centers in Milwaukee. They are: Columbia Hospital, County Emergency Hospital, County General Hospital, Johnston Municipal Hospital, and Milwaukee Children's Hospital. The Center maintains complete information on poisons by commercial name, ingredients, relative toxicity and treatment procedures.

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Esophagitis*

By MICHAEL W. SHUTKIN, M. D.**

Milwaukee, Wisconsin

NEITHER THE IGNORANCE of the past nor the profundity of the present can alter the realization that esophagitis is probably the most frequent abnormality of the esophagus. Allison[1, 2, 3] and Barrett[4] have emphasized the frequency of this affliction. The purpose of this report is to urge its abandonment as a clinical rarity and to recognize early its clinical and pathologic significance.

The swallowing mechanisms of the distal esophagus are decidedly different from those elsewhere in this organ. The work of Lerche[5] indicates that the structure and function of the lower esophagus is still not completely understood. His anatomical observations made on fixed post mortem specimens of the distal expulsive esophageal segment revealed a proximal and distal dilatation called the ampulla and vestibule, respectively, which are separated by the inferior esophageal sphincter. The vestibule is separated from the gastric cardia by the constrictor cardia muscle. Lerche[5] originally described the mucous membrane of the vestibule as esophageal, but Palmer[6] and others have shown in the living patient that it is lined with gastric mucosa. Motility and pressure studies in the esophagus have suggested that the vestibule has an independent motor function integrated in the over-all mechanism of swallowing. The nature of the cardiac sphincter is complex and its precise mode of action uncertain. There are three factors which apparently control it: (1) The circular muscle fibers at the terminus of the esophagus, (2) the right crus of the diaphragm whose fibers separate and surround the esophageal hiatus pulling it downward, and (3) the oblique entry of the esophagus into the stomach. The sharper the angle between the esophagus and fundus of the stomach, the less the chance of regurgitation. Alterations of these normal anatomicophysiological principles are clinically significant in the development of reflux esophagitis. There are many questions still unsettled and much work to be done regarding the surgical prevention and correction of esophageal reflux. The older, simpler hypotheses on competence of the cardia are open to serious question in the light of more incisive recent experiments. The resulting confusion perhaps is what promoted Johnstone[7] to urge that the anatomist, the radiologist, the physiologist, and the surgeon start anew to establish just what is true about the cardia.

Etiology

Inflammation of the esophagus may follow a variety of causes and is conveniently classified into three main groups: (1) acute esophagitis, (2) recurrent, acute, or subacute esophagitis, and (3) chronic esophagitis.

Acute esophagitis is principally an acute diffuse inflammatory reaction to chemical, thermal, mechanical, and infectious agents. The lesions may be catarrhal, pseudomembranous, ulcerative, pustular, phlegmonous, or gangrenous. Corrosives, ingested accidentally or by intent, cause extensive ulceration and sloughing which on recovery results in stricture. It is the intent of the author to give this category of esophagitis only brief and passing reference, permitting the major share of the discussion to the other two stages of this disorder.

When the effort is made to fill in the details of the broad etiologic outline of recurrent acute or subacute esophagitis, considerable difficulty arises due to a paucity of information regarding the basic physiology and anatomy of the esophagogastric region prior to the onset of regurgitation and esophageal inflammation. Confusion has, however, also been created by the use of a variety of names and, in fact, by the use of the same name for different conditions. In 1935, Winkelstein[8] described "peptic esophagitis" in association with duodenal ulcer, as a clinical entity. In 1943, Allison, Johnstone and Royce[9] described a group of cases with ul-

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ceration of the lower esophagus as "short esophagus with simple peptic ulceration". Despite the fact that in half their series biopsies revealed gastric epithelium, they believed that the ulceration occurred in squamous epithelium of the lower end of the esophagus. In 1946[1] and again in 1948[2] Allison stated that he considered peptic esophagitis, peptic ulceration, and peptic stenosis of the lower end of the esophagus to be stages in the evolution of the same disease. He preferred to emphasize the discrete ulceration rather than the diffuse inflammation by using the title, "Peptic Ulcer of the Esophagus". Barrett[4] later pointed out that the term, "peptic ulcer of the esophagus", had been applied previously to an esophageal ulcer with clinical and pathologic features markedly different from those described by Allison, *et al.*,[1, 2, 3] and that the unique feature of this ulcer was that it occurred in a length of esophagus lined by columnar gastric epithelium.

Clinically, there are two etiologic varieties of peptic reflux esophagitis: (1) following intubation, surgery, and persistent vomiting, and these are particularly severe when associated with duodenal ulcer; and (2) hiatus hernia of the sliding or rolling type which may be subacute or chronic.

Chronic esophagitis is concerned with the congenital short esophagus and with esophagogastric or marginal inflammation, following plastic procedures and in the chronic static dilatation observed in cardiospasm. Wolf, *et al.*,[10] have described this group under the title of, "Short Esophagus and Esophagogastric or Marginal Ulceration", based on roentgen and endoscopic features.

Aside from the more obvious etiology in acute esophagitis, the modus operandi in subacute-acute recurrent and chronic esophagitis is a failure of the cardioesophageal sphincter mechanism to function as an effective barrier against the reflux or regurgitation of the corrosive acid-pepsin gastric juice upon a vulnerable mucosa. Though this thesis is widely acceptable, it has been difficult to prove experimentally that reflux per se produces esophagitis. Achlorhydria is not infrequently observed. Reflux is not always demonstrable with esophagitis; many persons have marked reflux for years without signs, symptoms, or pathologic changes. Finally, combined radiologic, endoscopic, and biopsy study of patients with cardioesophageal incompetence has shown intermittent esophagitis which appears to heal spontaneously without any clear relationship to a variety of medical therapeutic programs.

Pathology

If Palmer[6] is correct, the pathologic series of events begin in the submucosa and not in the mucosa at all. This singular opinion is contrary to the generally accepted pathogenesis[12] of reflux esophagitis resulting from incompetency of the cardiac sphincter mechanism. In the early stages the mucosa may appear normal to esophagoscopy; later the mucosa becomes bluish-pink or velvety scarlet, bleeding easily when touched. The progressive pathologic picture reveals patches of desquamating epithelium followed by superficial oval mucosal ulcers. If healing and necrosis occur intermittently, the muscular coats of the esophagus are affected. The succeeding spasm with inflammatory changes in the muscle fibers results in fibrosis. Spasm and fibrosis of the circular muscle fibers produces stenosis, while spasm and fibrosis of the longitudinal muscle fibers shorten the esophagus. This shortening of the esophagus draws up the esophagogastric junction into the thorax, further impairing the function of the cardiac sphincter. In this manner, a vicious cycle is established: inflammation, fibrosis, constriction, and contraction produce stricture and shortening of the esophagus, retracting the stomach into the thoracic cavity and increasing the size of a coexisting hiatus hernia. In summarizing the pathology of ulceration in this process, it appears that in the thoracic portion of the alimentary canal there are two types of simple ulcers: (1) superficial and often intermittent ulcerations due to reflux esophagitis, and (2) chronic peptic ulceration situated in what is, in fact, a thoracic portion of the stomach.

Diagnosis

The diagnosis can be achieved with an accurate history, physical and roentgen examination, and esophagoscopy with biopsy. The differential diagnosis for the more advanced and complicated stages of esophagitis may find cytologic studies a further aid.

The characteristic symptoms with considerable latitude for variations are retrosternal pain, dysphagia, pyrosis, and regurgitation. The pain usually appears during the first hour after meals at the height of gastric

acidity and is often aggravated by stooping, straining, or lying down, all of which encourage the regurgitation of gastric juice into the esophagus.

In acute esophagitis severe substernal pain radiating to the neck, arms, or the scapulae with dysphagia may be an alarming symptom complex. Chronic esophagitis with its dull chest pain, pyrosis, and belching may easily be misinterpreted for a neurosis or angina pectoris.

The radiologic examination is invaluable for the diagnosis of late esophagitis, but may be negative in the early stages. The esophagitis following the ingestion of corrosives and poisons characteristically resolves itself into an elongated stricture. The reflux lesion with a barium study will reveal annular spastic contraction, longitudinal shortening, stricture, peptic ulcer, with and without hiatus hernia. These occur singly or in combination.

Esophagoscopy can confirm the diagnosis of esophagitis. It may be possible to introduce the scope to the region of the intrinsic sphincter indicating that the severe narrowing seen on roentgen examination in the early stages is predominantly due to spasm. In the typical case, in addition to the narrowing of the lower third of the esophagus, there is a reddish hue to the esophageal mucosa in sharp contrast to the normal yellowish tint. Multiple irregular erosions covered by whitish plaques surrounded by hyperemic halos are characteristic. These erosions or ulcerations are frequently longitudinal and may extend to the esophagogastric junction. Pin-point submucosal hemorrhages may be prominent. Tissue biopsy is only indicated to rule out malignancy where there is tumor or obstruction.

Differential diagnosis includes angina pectoris, cholecystitis, peptic ulcer, carcinoma of the esophagus, cardiospasm, and peptic ulceration of the thoracic stomach.

The prognosis of acute esophagitis will depend on the severity of the insult and the adequacy of the immediate and prophylactic treatment. Once the esophagus has been severely injured, a stricture may form at any time during the life of the patient. The final outcome of esophagitis due to prolonged vomiting or debilitating disease will largely depend on the primary cause of the disorder. In patients whose esophagitis is due to incompetence of the cardiac sphincter mechanism, the prognosis depends on the presence of complications particularly coexisting duodenal ulcer, stricture, or massive hemorrhage. In the uncomplicated case the prognosis is favorable. Even if untreated, the majority of these patients with simple esophagitis usually follow a normal existence except for heartburn and occasional pain, which often responds to a medical regimen. It is in that small group of patients with extremely severe symptoms, high acidity, a large hiatus hernia, chronic inflammation, and ulceration of the esophagus, that stricture, perforation, or hemorrhage may develop.

Treatment

Treatment will depend upon the severity of the symptoms, the age of the patient, and the presence of complications. Medical treatment is effective and sufficient for most patients with simple esophagitis. An outline of medical treatment for esophagitis involves:

1. Symptomatic, supportive, and rehabilitative measures where indicated.
2. Dietary control with a bland, ulcer-type diet fortified with multiple vitamin supplements and hematinics where iron deficiency exists.
3. Antacids orally; when necessary, they may be supplemented with continuous nocturnal drip techniques using milk or aluminum hydroxide suspensions.
4. Anticholinergics, sedatives, and antispasmodics in response to indications.
5. The elimination of postural factors, abdominal constriction, and distention, all of which may promote regurgitation of gastric secretion.
6. Esophageal dilatation for stricture.

The concept of surgical therapy[13] in peptic esophagitis is directed toward the reconstitution of the cardiac sphincter mechanism, diminution of acid peptic secretion, adequate gastric drainage, and spatial separation of the vulnerable esophagus by the interposition of jejunum. When the relationship of esophagitis and advanced, complicated hiatal hernia can be established, repair of the hernia is the treatment of choice. There is no disagreement with the view that surgery is indicated for irreversible degrees of stricture, hemorrhage, and for the rare occasions of perforation.

Summary

Esophagitis is probably the most frequent abnormality of the esophagus, yet the diagnosis is made too infrequently.

The modern descriptions of the anatomy and physiology of the esophagogastric sphincter mechanism have partly clarified the pathogenesis of the larger group of esophagitis which excludes that caused by ingested corrosives and poisons.

Failure of this sphincter mechanism as an effective barrier results in the reflux of corrosive gastric juice. The resulting esophagitis which is observed most often with hiatal hernia, also occurs following intubation, severe vomiting, and plastic operations on the esophagogastric junction. A coexisting duodenal ulcer increases the severity of the esophagitis and is a threatening factor in stricture formation. It is clinically significant that esophagitis coexists in over half the cases of pyrosis and this association is worthy of vigilance.

Surgeons should be alerted to the serious complication of ulcerative esophagitis, and stricture that not infrequently follows postoperative intubation for duodenal ulcer while plastic surgery on the esophagogastric segment rarely escapes a similar fate.

Therapy has a rather distinct division into medical and surgical procedures which are outlined and briefly discussed.

606 West Wisconsin Avenue.

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Lay Film on "Congenital Heart Defects" Available

"Congenital Heart Defects," latest film in a series on the cardiovascular system and its diseases for presentation to professional workers, students and the general public, is now available from the Wisconsin Heart Association on a rental basis.

In explaining the underlying physiology of a number of congenital heart defects, the film, like others in the series, makes effective use of animation. The structure of the normal heart and how it works are shown in animated diagrams. Five common defects that may be helped by surgery are contrasted with the normal heart. These include patent ductus arteriosus, coarctation of the aorta, valvular pulmonary stenosis, tetralogy of Fallot, and an arterial septal defect.

Earlier films in the series, produced for the American Heart Association and its affiliates by Churchill–Wexler Films, are: "Varicose Veins," "Circulation of the Blood," "High Blood Pressure," "Strokes," and "Coronary Heart Disease." All of the films, which are 16mm. and run under 10 minutes, are cleared for television use.

Tietze Syndrome; A Report of Four Cases*

By AUSTIN J. McSWEENEY, M. D.

Janesville, Wisconsin

TIETZE SYNDROME is a disorder which has only recently aroused extensive interest in the American medical profession. Although Tietze[1] reported the syndrome of painful enlargement of costal cartilages in 1921, the first American paper describing this condition was not published until 1953. At that time Motulsky and Rohn[2] presented two cases associated with pulmonary Hodgkin's disease. Subsequently there have been at least 38 other examples of Tietze disease reported in this country, and there is a growing suspicion that the malady is much more common than this number of reports would indicate.

Tietze disease has been variously referred to as painful nonsuppurative swelling of costochondral cartilages, chondropathia tuberosa, costochondral syndrome, costal chondritis, sternochondralgia, and prominent costal cartilages. Since the pathogenesis of the disorder is unknown, the eponym designation enjoys common use. Recently Salomon[3] coined a new name, thoracochondralgia, and proposed that this term be substituted for Tietze syndrome. Tietze originally suggested that tuberculosis or war time malnutrition might have been etiologic factors, but subsequent investigation has not confirmed these concepts. Motulsky and Rohn suggested that either microtrauma or rheumatoid disease of the intra-articular sternocostal ligament might be an important factor in the etiology of the syndrome. This ligament is an inconstantly present strong fibrocartilagenous structure which may extend from the medial end of the rib cartilage to the sterno-manubrial symphysis. It is usually present at the second sternocostal junction and is found with decreased frequency at the third and fourth sternocostal joints. It is still more rare in the remaining sternocostal articulations and this could account for the more frequent occurrence of Tietze disease in the upper costal cartilages.

Beck and Berkheiser[4] reported that surgical exploration of a case had shown the affected cartilage to be buckled forward. These authors suggested that the syndrome described by Tietze might not be a disease of cartilage at all but an inflammatory reaction contracting ligaments immediately posterior to a costal cartilage and thereby buckling the rib cartilage secondarily.

Karon, Achor, and Janes[5] recently pointed out that the natural history of the costochondral syndrome is in keeping with the changes one might expect from a simple sprain involving the ligaments and capsules of the costosternal joints. Most sprains require five to six weeks to heal. These same authors also proposed that costosternal synovitis either as the accompaniment of a sprain or secondary to an inflammatory process could account for the clinical manifestations of Tietze syndrome. In the present state of our knowledge it seems best to concede that the cause of the disorder is still not established.

No consistent histopathologic picture has become apparent on study of the affected costal cartilages. Pathologists commonly report such findings as hyperplasia and metaplasia of the cartilage with bone formation, thickening of the perichondrium, muscle, fascia, and adjacent ligaments, and often they encounter histologically normal cartilagenous tissue.

Clinically Tietze syndrome is characterized by painful enlargement of one or more costal cartilages and adjacent ribs associated with local tenderness. The second rib cartilage alone is reported to be involved in about 60% of the cases, and the left side is more commonly affected than the right. The condition is also known to occur at a sternoclavicular junction, and a case with involvement of the crico-arytenoid joint has been

* Presented at the one hundred seventeenth meeting of the State Medical Society, May 7, 1958, Milwaukee, Wisconsin.

reported.[6] Generally, swelling and pain reach a maximum within a day or two and then gradually subside over a period of three to four weeks.[7] However, some residual enlargement may remain for months or even permanently. Characteristically, the skin overlying the tumor mass is normal in appearance; and there is no local warmth or erythema. Pain in the affected area may precede the onset of tumefaction. Although this pain is increased by deep inspiration, coughing and sneezing, it may be dull in character in contrast to the sharp, stabbing pain of pleurisy. The intensity of pain and tenderness varies considerably. In some cases no therapy other than reassurance is required; whereas in others the pain may be severe and the tenderness may be exquisite.

Various forms of treatment have been employed. The application of heat locally and the use of analgesics may provide symptomatic relief. Deep x-ray therapy, nitrogen mustard, local infiltration with procaine, corrective postural exercises, the use of bedboards, and surgical removal of the involved cartilage[8] have been advocated. Since all reports of the costochondral syndrome indicate that it is an entirely benign and self-limited condition, it is particularly desirable that therapeutic measures be moderate in nature. However, when pain is severe and persistent, the customary conservative measures are often inadequate. Although total excision of the offending tissue produces a reliable and permanent cure, this vigorous management of a rather innocent disease seems inappropriate. The author recently had occasion to cope with this problem of severe painful swelling of a costal cartilage and found that oral steroid therapy is a simple and effective remedy.

Report of Cases

Case 1: A 35-year-old Caucasian male, automobile assembly line worker, came to the clinic in June 1957 complaining of chest pain of five to six days' duration. The pain was gradual in onset and was situated in the left lower anterior chest wall. Its character was dull and its intensity moderate. Pain was increased by deep inspiration, coughing, sneezing, twisting, or turning movements of the torso, bending forward, and by external pressure in the area of the seventh costal cartilage. A chest x-ray taken on the day of the examination was not remarkable. The patient's lower ribs were immobilized with an adhesive tape strap, and this produced immediate diminution of pain. Two days later the patient noted increasing pain and tenderness associated with local swelling in the affected area.

He was hospitalized on June 10, 1957, because of severe chest pain. Physical examination revealed a blood pressure of 130/84, pulse 88, and oral temperature 99.2 F. There was a tender, fixed fusiform mass, roughly 4 cm. in length which appeared to represent a localized expansion of the seventh costal cartilage in the left anterior axillary line. This mass was plainly visible on inspection and was elevated 1 to 2 cm. The overlying skin was normal in appearance and mobile. Complete physical examination was otherwise not remarkable. The chest x-ray and spot film of the tumor mass showed no abnormality. The complete blood count revealed hemoglobin 15.1 gm., leukocytes 9,800 with 65% neutrophils, 5% eosinophils, 22% lymphocytes, and 8% monocytes, and sedimentation rate of 5 mm. per hour. The test for C-reactive protein was negative and the urinalysis showed no abnormality.

The patient was treated with aspirin, meprobamate, hot packs and a chest binder. These measures, however, afforded him inadequate relief of pain. His distress was considerable although he had been assured that the condition was harmless and self limited.

Surgical exploration and biopsy confirmed that the tumor mass represented cartilagenous enlargement at the costochondral junction. Sections were sent to the Mayo Clinic and these were described as follows: "In our opinion your slides show the active new bone formation such as one gets following a fracture or perhaps some strange inflammatory process. We see no evidence of malignancy, so please let me know if it metastasizes." (Fig. 1). Culture of bone curettings from the costochondral junction produced a nonhemolytic streptococcus.

On June 16, 1957, all existing therapeutic measures were cancelled and treatment with prednisolone, 5.0 mg. every six hours orally, was initiated. Marked lessening of pain occurred within 24 hours. In an additional 24 hours the patient was entirely pain-free, and there was minimal tenderness at the tumor site. He was dismissed from the hospital feeling quite well, and prednisolone therapy was discontinued abruptly after 12 symptom-free days. In 24 to 36 hours pain had recurred with almost its original intensity. Re-examination of the patient showed definite recurrence of tenderness in the tumor mass. The patient was again put on prednisolone, and over a period of 24 to 36 hours pain and tenderness vanished. Steroid therapy was discontinued on July 16, 1957, and the patient remained symptom-free. Diminution in the size of the costal cartilage was first noted by the examiner on July 6, 1957, and the mass was gone by July 24, 1957.

Four months later while using an electric screw driver, the patient experienced a snapping sensation in the area of the third right costochondral junction. At the time that this happened, he was straining in the physical effort of his work, and he likened this snapping to the sensation perceived when a comb breaks in one's hip pocket. It was not painful and probably would have gone entirely un-

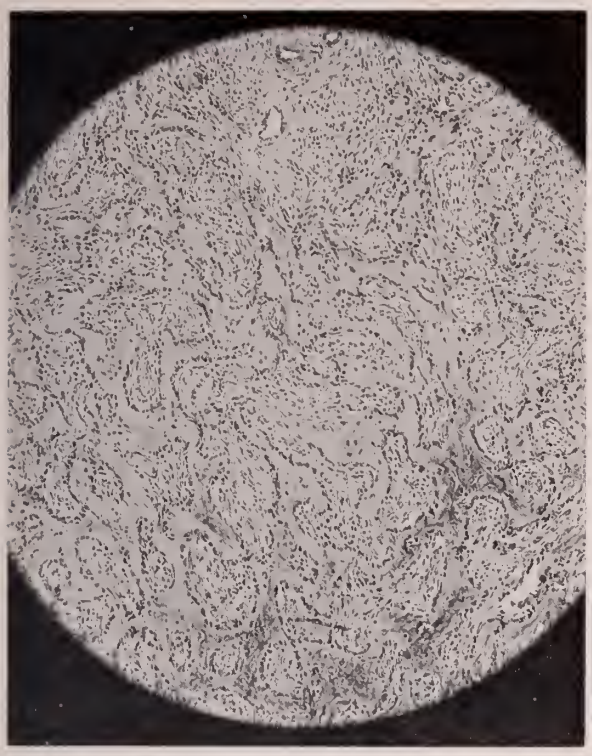

Fig. 1—Biopsy specimen (X75).

noticed had the patient not been made psychologically sensitive to chest wall symptoms by his earlier experience with the costochondral syndrome. An hour or two after this snapping sensation occurred the patient gradually developed mild, dull aching in the right anterior chest wall. This pain gradually increased in intensity and the patient stayed home from work the next day.

On November 14, 1957, when the patient presented himself at the clinic for examination, he was found to have a 2 to 3 cm. fusiform tender mass at the right third costochondral junction. Although the patient was treated with propoxyphene, he continued to complain of severe pain. Because of this intractable pain he was readmitted to the hospital on November 19, 1957. Complete physical examination contributed no additional pertinent data. The chest x-ray was normal. The complete blood count disclosed a hemoglobin of 14.9 gm., leukocytes 15,650 with 74% neutrophils, 2% eosinophils, 22% lymphocytes, and 2% monocytes. The sedimentation rate was 10 mm. per hour. The test for C-reactive protein was one plus, and the urinalysis was not remarkable.

Prednisolone therapy was started promptly as before and in three days both pain and tenderness were definitely diminished. In an additional week, pain had subsided entirely and only slight residual tenderness remained. Successive studies of the white cell series showed gradual changes toward normal until that status was finally achieved on December 6, 1957. On March 19, 1958, the date of the patient's last examination, he was asymptomatic and in excellent health.

Case 2: A 22-year-old, white, automobile assembly line worker was referred to the clinic on December 19, 1957, because of severe pain of three days' duration eminating from the right sixth costochondral junction. He had been in good health until a week and a half earlier when he developed a cough, sore throat, and rhinorrhea. On December 16, 1957, he noted the gradual onset of mild stabbing, right lower anterior chest pain. This discomfort slowly increased in intensity until the following day when he experienced a snapping sensation in the area of pain several times in the course of a paroxysm of coughing. About 10 to 15 minutes later, the pain became very severe and it remained severe subsequently. The pain would become maximal when the patient would cough, inspire, breathe out forcefully, rotate his trunk, or bend forward. His physician applied a chest binder and this afforded the patient partial relief of his pain. His past history and family history revealed no information relative to the current illness.

On examination the patient was seen to be a well developed, young, adult male with a muscular physique and who was in obvious distress because of pain. The blood pressure was 130/70, pulse 72, and the oral temperature 98 F. Except for occasional inspiratory dry sibilant rales in the right lung field, positive findings were limited to the right sixth rib cartilage. Here swelling was noted on inspection, and palpation revealed both enlargement and marked tenderness of the costochondral junction. The chest x-ray, complete blood count, test for C-reactive protein, sedimentation rate and urinalysis revealed no evidence of pathology.

This patient's response to oral prednisolone therapy was also very satisfactory. Twenty-four hours after treatment had been started both spontaneous pain and local tenderness were much diminished. In an additional day the patient was entirely free of pain and there was only minimal residual tenderness at the affected costochondral junction. A follow-up chest x-ray on January 3, 1958, was not remarkable. The patient was last examined on January 10, 1958, and although there was still slight local tenderness and slight enlargement of the cartilage, there had been no recurrence of pain. In a recent communication with the patient he stated that local tenderness had subsided entirely in an additional two weeks and he has subsequently been well.

The rather remarkable influence of prednisolone upon the course of the preceding two cases of Tietze disease prompted us to review the literature for reports of similar experiences by other clinicians. In 1955 Celio and Nigst[9] reported treating two cases of Tietze disease with local injections of hydrocortisone. Case 1 was given three injections within a period of one week. After 12 days

Table 1—Reports of Steroid Therapy in Tietze Disease

Case	Author	Age and Sex	Steroid		Thoracic Cartilage	Duration of Pain After Therapy Started
			Type	Treatments		
1	Celio and Nigst	M 30	Hydrocortisone in loco	4	L-2	3 weeks
2	Celio and Nigst	M 32	Hydrocortisone in loco	1	R-3	10 days
3	McSweeny, et al.	M 35	Oral Prednisolone		L-7 R-3	2 days 10 days
4	McSweeny, et al.	M 22	Prednisolone		R-6	2 days
5	Salomon	M 31	Hydrocortisone in loco	5	L-4	2 weeks
6	Salomon	M 33	Hydrocortisone in loco	4	L-4	2 weeks
7	Salomon	F 28	Hydrocortisone in loco	5	Rt. sterno-clav. joint	Still present on 4/15/58 (Reported 2/15/58)
8	Karon, et al.	M 36	Hydrocortisone in loco	1	L-2	4 days
9	Karon, et al.	M 58	Hydrocortisone in loco	1	R-2	3 months
10	Karon, et al.	F 46	Hydrocortisone in loco	1	L-3, 6	3 weeks
11	Karon, et al.	M 48	Hydrocortisone in loco	1	L-4	3 months
12	Karon, et al.	M 35	Hydrocortisone in loco	1	R-1, 2	2 months

the swelling was entirely gone and the pain diminished. Another injection was given at that time and after an additional 10 days there was no spontaneous pain and only slight discomfort on pressure. In Case 2 the swelling disappeared in a matter of a few days after the injection, and the patient was free of discomfort 10 days after the local injection of hydrocortisone. The patients were followed up for one year with no apparent recurrence, and the authors recommended local hydrocortisone as a very effective procedure.

Not long after the author and his associates had submitted a preliminary report of the value of oral steroid therapy,[10] ten additional cases of successful treatment of Tietze disease by local hydrocortisone injections appeared in the literature. Table 1 summarizes all known reports of steroid therapy in Tietze disease.

Oral prednisolone was not employed in the following two cases of painful nonsuppurative swelling of the costochondral cartilages. Although these two interesting patients fulfilled the criteria necessary for the diagnosis of Tietze disease, their pain was not severe. In fact, the author's interest in their presenting complaints far exceeded their own. It is not difficult to envisage that many similar cases have occurred but have not been reported in the American literature.

Case 3: A 51-year-old, Caucasian, female secretary consulted us on February 3, 1958, because of chest pain of three to four days' duration. She had apparently been in good health until about a month earlier when she developed an upper respiratory infection with coughing and nasal discharge. She visited her local physician promptly and was given a four-day course of tetracycline therapy. Although the acute coryza subsided, the patient was left with a persistent nonproductive cough. About a week before visiting the clinic she developed another upper respiratory infection; and she refilled her tetracycline prescription, taking 250 mg. four times a day. The onset of chest pain was gradual and it emanated from the area of the right third costochondral junction. The pain was of moderate intensity and it was increased by coughing, by turning her body, or by moving the right upper extremity. While the chest pain was never severe, it had passed its peak of intensity and was slightly diminished on the day the patient came to the clinic. She also complained of local tenderness in the affected area. The patient gave a past history of pneumonia in 1950, 1954, and 1956. One of her brothers had died of a spontaneous pneumothorax. Her personal and family history were otherwise noncontributory.

Examination disclosed a mildly obese, middle-aged, white female with a blood pressure of 134/94, pulse 84, and oral temperature 98 F. Positive abnormal findings were limited to the region of the right third costochondral junction where there was a localized

elevation in the skin surface of 0.5 to 1 cm. Palpation of this spot revealed the presence of a hard tender mass which could be recognized as an enlargement of the costochondral junction. The chest x-ray disclosed absolutely no pathology.

After informing the patient of the benign nature of her chest pain, she was given a prescription for propoxyphene which afforded her gratifying relief of discomfort. Spontaneous pain had subsided entirely by February 26, 1958. However, there was still minor residual tenderness and slight enlargement of the affected costochondral junction on March 12, 1958, when the patient last visited the clinic.

Case 4: A 27-year-old, white housewife seen at the clinic on January 8, 1958, presented a complaint of chest wall pain of two and one half weeks' duration. Her past health had been excellent and a chest x-ray made in 1957 was reported as normal. A day or two before Christmas the patient developed an upper respiratory infection with coughing and nasal discharge. At the time of the patient's examination, mild residual cough was still present and coughing would increase the patient's chest pain. Chest pain also increased with forced inspiration. The pain was dull in character and at no time was it severe. Neither the past history nor the family history contributed any additional pertinent data.

On examining the patient her blood pressure was found to be 132/72 and her oral temperature was 99.8 F. She was well-developed, well-nourished, slender, and in no obvious distress. Positive findings were in this case also limited to a rib cartilage. The right fifth costochondral junction was swollen and tender. No therapy was given to this patient since her pain was not distressing. Although she failed to return for further examination, the patient reports that her discomfort gradually disappeared in a period of about three weeks and local tenderness was gone a few days later.

Summary and Conclusions

Four cases of Tietze's syndrome and results of treatment with prednisolone in two of these have been described. All known reports of steroid therapy have been summarized and tabulated. Since the results of treatment with oral prednisolone compare favorably with those of local hydrocortisone injection, further trial of oral steroids in the treatment of painful nonsuppurative swelling of costochondral cartilages seems warranted. It is proposed that the curious syndrome which Tietze described may be much more common in this country than is suggested by the dearth of reports in the American literature.

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TOXIC MANIFESTATIONS FROM OVERDOSAGE OF DIGITALIS are well known, but the occurrence of a true allergic reaction to digitalis is so uncommon as to be seldom considered by most doctors. A 47-year-old woman with rheumatic mitral valvular disease who underwent surgery subsequently developed urticarial lesions following the administration of digitalis. Intravenously administered diphenhydramine provided helpful relief. Although this patient had exhibited urticarial reactions repeatedly after the administration of different forms of digitalis by different routes, she failed to show a response to skin-test doses of various forms of digitalis, eosinophilia, signs of serum sickness, or an anaphylactoid type of reaction. This would seem to be the rule rather than the exception in digitalis-induced allergies.—Skaggs, Ray H.: Allergic Reaction to Digitalis, Texas State J. Med. 55:54–55 (Jan.) 1959.

Accidental Overdosage of Morphine used as Preanesthetic Medication

Presented under the direction of the Wisconsin Society of Anesthesiologists

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MORPHINE AND OTHER OPIATES are known to produce respiratory depression, characterized by slowing of rate, and in severe cases, markedly inadequate ventilation resulting in oxygen want and inadequate removal of carbon dioxide. In many patients, depression of circulation with slowing of pulse rate and fall in blood pressure, especially with change in position, may be seen.

The availability of specific antagonists to the depressant action of these drugs, such as n-allylnormorphine (Nalline) and levallorphan (Lorfan) has made it possible to treat the depression caused by overdosage of opiates. This has proved to be of value in anesthesiologic practice when undue depression of respiration results from usual doses of preanesthetic medication, especially in combination with anesthetic agents which are depressant in their own right or when there may have been inadvertent overdosage of the narcotic.

Two cases are presented to illustrate overdosage of morphine:

Case 1: A 73-year-old male was scheduled to have a common bile duct exploration. He had lost 15 pounds of weight in recent weeks, suffered from arteriosclerotic heart disease which required digitalization, and there was electrocardiographic evidence of previous myocardial infarction. Blood pressure was 110/70. Preanesthetic medication, consisting of atropine 0.4 mg. was ordered to be given 1 hour before the induction of anesthesia was begun. After some 6–8 breaths of cyclopropane, the patient's respiration became periodic in nature. His blood pressure had been 80/60 before the anesthetic was started, and shortly became unobtainable. The pulse was noted to be thin in quality. After the agent was stopped, and only oxygen given, the blood pressure rose to 110/70. When an attempt was made to administer cyclopropane again, his respiration again became irregular with periods of apnea, and it was decided to abandon attempts at anesthetization of this depressed patient. There was no further hypotension, and although his respiration remained slow it was deemed to be adequate during his recovery.

When the patient had been returned to the recovery room, it was noted that the preanesthetic medication recorded on the nurse's notes was morphine 0.4 mg. instead of atropine 0.4 mg. which had been ordered. Questioning of the nurse revealed that she had indeed given morphine, but that the dose was 15 mg. (gr. ¼). How she made this error in both drug and dose is not known.

Case 2: A nine-year-old girl in very good general health was scheduled to have an amputation of a toe, deformed by syndactylism. Her weight was 53 pounds. Sedation with morphine 5 mg. and scopolamine 0.2 mg. was ordered, and on arrival in the operating room she appeared well sedated. Induction of anesthesia was with thiopental 100 mg. intravenously, followed by nitrous oxide and oxygen. An additional 100 mg. of thiopental was given during the procedure. The patient did not breathe during the entire operation, which lasted for 35 minutes. At first this was thought to be due to breathholding in response to the stimulus of the surgical incision. Later there was apparent cyanosis, which was improved after correction of an obstructed airway, and by the administration of increased oxygen concentrations. Artificial respiration was maintained throughout, with the patient making no effort at respiration. At the end of the operation, the nitrous oxide was discontinued, and ventilation with oxygen at a lower rate resulted in resumption of spontaneous respiratory effort at a rate of 5 per minute. It was thought that she might have been overly depressed by the preoperative narcotic, so levallorphan 0.5 mg. was given intravenously. This produced an immediate increase in respiratory rate to 14 per minute, and return of pharyngeal reflexes. After an hour in the recovery room, the respiration again be-

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came slow, and again responded to levallorphan 1 mg.

After the operation, and the first dose of levallorphan, it was reported by the nurses from the ward that this patient had been given 25 mg. of morphine instead of the 5 mg. which had been ordered. Her postoperative course was uncomplicated.

In the first of these cases the patient was noted to have depression of blood pressure before the attempted induction of anesthesia. When severe depression of respiration, characterized by periodicity, and marked additional depression of circulation were produced when cyclopropane was started, the attempts to prepare him for the operation at that time were discontinued. If it had been known that a dose of morphine much too great for a man of his age and condition had been given, it might have been treated by the use of an opiate antagonist. This might well have made it possible to continue with a satisfactory induction of cyclopropane anesthesia. Since it was not known that an opiate had been given, it was not advisable to use one of these antagonistic drugs which may produce depression in their own right when not given in the presence of an opiate.

The second patient was thought to have had what should have been a suitable dose of morphine for her age and weight (0.1 mg. per pound), but showed signs of severe respiratory depression. Because of this, she was given levallorphan in an attempt to reverse this depression. After it was discovered that she had been given five times this dose of morphine, a subsequent dose of antagonist was needed.

Careful consideration of the dose of narcotic to be used for preanesthetic medication will avoid undue depression in most patients. Many patients may need no opiate, and will breathe better without it during anesthesia when those agents which depress the respiratory center are used. Some patients will be more than usually depressed by the opiate used, and in these cases it is often possible to produce great improvement in respiration or in circulation by the administration of an opiate antagonist.

Occasionally patients will be given wrong doses of narcotics. The two patients reported here were given excessive doses of morphine because of nursing errors. There have been other errors such as giving the injection to the wrong patient, or having a second nurse repeat the injection, not knowing that the medication had already been given. We have seen an error result from writing the order on the wrong order sheet, so that a patient received what for him was a gross overdosage. One anesthesiologist intended to order meperidine, but absent-mindedly wrote Pantopon 75 mg. on the order sheet. His patient was given a dose of opiate several times greater than he intended. Such errors are fortunately rare, but should be reported and treated promptly when they are discovered.

Another way in which errors can occur is in the conversion of doses from the apothecary to the metric system. The routine use of the official (since 1943) metric system should eliminate the problems caused by the troublesome arithmetic of dividing fractions. In preparing the small doses of opiates appropriate for infants and children, it is well that instruction be given in the proper method of dilution of the larger size tablets so that the proper dose can be given in an accurately measurable volume of ½ to 1 cc.

All possible care should be taken in the ordering of narcotics to make the orders clear to those who will be administering these potent agents. When patients show signs of undue degrees of depression from normal doses of drugs, or when accidental overdosage, such as reported above, produces severe depression of respiration or circulation, then the use of the opiate antagonists will be of great assistance in treating this complication.

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ANEMIA IN ELDERLY PEOPLE IS MORE OFTEN CAUSED by an insufficient iron supply in the diet than by inadequate absorption. Their arbitrary diets contain food with a low iron content (50 to 70% of required amounts).—Lange, Henrik F.; Skjaeggestad, Öivind: Iron Deficiency Anemia in Old Age, Acta Med. Scandinav. 162:321–326 (Nov. 10) 1958.

Hypertension Screening Project

A Progress Report

By DONALD C. CAMERON, M. D.*
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ALMOST A YEAR has elapsed since the State Board of Health launched its pilot study project on hypertension screening.[1] While follow-up information will not be available for analysis for some time, it is felt that a progress report and a restatement of objectives will be of interest.

It has been demonstrated that the 70 mm. x-ray chest survey can be an effective case-finding mechanism for heart disease in a general population.[2] However, it is equally well established that heart disease cannot usually be discovered early in its development by means of chest x-ray[1, 2] for the simple reason that cardiac enlargement is a relatively late manifestation. Therefore, we should focus our attention on other useful means of earlier detection of heart disease or, better still, its predisposing factors. Hypertension is a major predisposing factor and its treatment is becoming more rewarding every year as new drugs are developed.

In the five-month period from July 1958 through November 1958 about 20,000 persons had their blood pressure taken when they visited a State Board of Health mobile x-ray unit. Of this number, almost 2,000 individuals were found to have blood pressure readings which exceeded the screening level of 160/100. These referred persons represent 10% of the total screened population. Because the follow-up data on these people is not yet available, we cannot say how many of these referrals have been confirmed by the family doctor. However, according to a follow-up study of a small group of referrals early in the screening project, we can estimate that the family doctor will agree that hypertension is present in about three fourths of the referred individuals. This same early study gives evidence that more than half of these confirmed cases of hypertension will be previously unknown.

Of the 2,000 referrals in this five-month period, approximately 1,500 were made because the systolic blood pressure alone was elevated, 150 because the diastolic alone was elevated, and 350 because both systolic and diastolic readings were elevated above screening levels. There is reason to believe that the confirmation rate will be particularly high in the last two groups, and that most "false positives" will come from the first group. If these suspicions are substantiated by the follow-up information, it is probable that, in the future, referrals will be made only in these last two categories.

Follow-up studies may also demonstrate that greater allowance should be made for the known correlation between advancing age and a higher "normal" blood pressure. This might be done by establishing a different screening level for each of several age groups. Such action would tend to increase the proportion of meaningful referrals among the older age groups.

This would seem to be an excellent opportunity to stress the importance of the "follow-up" procedure in any project such as this. It has been suggested here that program evaluation and needed modification can only be based on the follow-up information obtained from the examining physician. Only if the post-referral status of the patient is known to us can we increase the efficiency of the program. It is to the credit of Wisconsin's physicians and the cooperation they have given that this project is expected to introduce many people with unknown and asymptomatic hypertension to the benefits of early discovery and early medical supervision.

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International Experience with Tolbutamide (Orinase)

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IN WHAT FOLLOWS I shall present the essence of the findings in seven articles from the recent literature, chosen not only because they are representative of what is being done with tolbutamide (Orinase) in the oral therapy of diabetes mellitus but also because they originate in six distinctly different geographic areas and are thus indicative of the worldwide experience.

In the first,[1] an American article, there is substantiation of the earlier impression that best results are usually to be expected in patients whose diabetes was detected after age 40 and whose insulin requirement is below 20 units.

In the second,[2] also an American article, it is shown that the result obtained in the early trial of the drug in an individual case may not be reliably indicative of the ultimate responsiveness of the patient since an early resistance may be overcome or, contrariwise, an early favorable response may fail to be sustained.

In the third,[3] a Scandinavian article, evidence is presented that the development of resistance to the drug in patients who had responded initially does not imply that insulin requirements will be increased when therapy with the hormone has been resumed.

In the fourth,[4] an Indian article, the necessity for accompanying dietary restrictions is shown, and it is made apparent that the drug becomes less effective as the patient's weight is allowed to increase.

In the fifth[5] article, the one from England, there is evidence that tolbutamide action is independent of the patient's age, weight, and heredity and of the symptoms and duration of the disease, but depends entirely on the severity as revealed in the insulin requirement.

In the sixth,[6] a South African article, it is shown that the optimal tolbutamide effect is often delayed and that even greatly increased dosage cannot control the hyperglycemia and ketosis associated with intercurrent infection, injury, major surgical procedures, etc.

Finally, in the seventh,[7] a French article, the attempt is made to classify cases of diabetes on the basis of response to tolbutamide.

The total number of cases involved in these combined studies was 1,618, and the incidence of untoward side-actions or toxicities was strikingly low: very little significant hypoglycemia; a few instances of urticaria or skin rashes; some minor gastrointestinal disturbances; an instance of activation of duodenal ulcer with melena; headache, muscular weakness, tingling, hemiparesis associated with hypoglycemia; transient alterations in the platelet count; temporary reversal of the neutrophil-lymphocyte ratio (in 37 of the 105 South African cases); an instance of severe leukopenia which resolved without alteration in dosage. However, there is considerable variety here, and I should say that we are not yet able to delineate fully the potential toxicity of this drug. At two autopsies on patients whose deaths were unrelated to the administration of tolbutamide there was no pancreatic or hepatic damage attributable to the drug.

In articles not included in this series of seven there was reported[8] an instance of nephrosis occurring during tolbutamide administration but not conclusively ascribable to it, and[9] two instances in which diabetic acidosis promptly developed when tolbutamide was substituted for insulin.

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9. Engstrom, W. W., *et al.*: Diabetic acidosis as a complication of therapy with tolbutamide, G. P. 17: 96, 1958.

A REVIEW OF THE LITERATURE REVEALED that penicillin-contaminated dairy products have previously been suspected but never proved to be a cause of allergic reaction. In this paper, 4 cases are reported which provide proof for the first time that traces of penicillin contaminating dairy products cause allergic reactions. This proof is based on the following evidence: (1) each of the patients had previously experienced a typical allergic reaction to penicillin; (2) the previous symptoms of known penicillin reaction were duplicated repeatedly after the ingestion of dairy products; (3) the reactions cleared rapidly following an injection of 800,000 units of penicillinase, a penicillin-destroying enzyme with no effect on anything but penicillin; and (4) the patients could ingest dairy products without subsequent allergic reactions if they were given a prophylactic injection of penicillinase first. More stringent efforts should be made to eliminate penicillin contamination of American milk. In 1957, it was estimated that 11% of milk samples were contaminated with measurable amounts of penicillin. Patients with chronic urticaria where penicillin sensitivity is suspected should be given 800,000 units of penicillinase. If the urticaria clears within 12 to 96 hours and stays clear for 4 to 7 days, penicillin sensitivity was probably the cause. Patients with chronic urticaria, where penicillin sensitivity is proved or suspected, should be instructed to eliminate dairy products, ice cream, and Roquefort or bleu cheeses containing Penicillium species molds from their diets. If a patient experiences a flare-up of urticaria 4 to 7 days after remission has been induced by a penicillinase injection, there is residual penicillin in the system which has not been destroyed, and penicillinase injections should be repeated at 4- to 7-day intervals, as needed, to stop the symptoms. If more than 8 days elapse before a new outbreak of allergic symptoms after an injection of penicillinase, the injection has destroyed all the penicillin in the system at that time. The new outbreak suggests that either the patient has had a new exposure to penicillin or the new reaction is due to some other allergen.—Zimmerman, Murray C.: Chronic penicillin urticaria from dairy products, proved by penicillinase cures, Arch. Dermatol. 79:1–6 (Jan.) 1959.

STATUS EPILEPTICUS IN AN 11-year-old girl was successfully treated with tubocurarine and controlled respiration after the condition had not responded to treatment with paraldehyde, phenobarbitone, hyoscine, and oxygen therapy. Treatment with tubocurarine and controlled respiration provided rapid relief from respiratory insufficiency without adding to the cardiac embarrassment, it enable the adequacy of the airway to be maintained by an endotracheal tube and the obstructing material in the respiratory passages to be removed easily by suction, and it probably helped prevent pulmonary edema by countering the tendency for an increased amount of fluid to leave the pulmonary capillaries. Since tubocurarine has no central anticonvulsant action, it should be used in combination with an agent such as phenobarbitone.—Nisbet, H. I. Armstrong: Status epilepticus treated with d-tubocurarine and controlled respiration, Brit. M. J. 1:95–96 (Jan. 10) 1959.

The President's Page . . .

Critical Need for Treatment Center

WISCONSIN LEGISLATORS face an important decision in coming weeks as they come to grips with several mental health proposals. One of these, Bill 3, S. for the establishment of a treatment center for emotionally disturbed children, demands immediate approval.

Only three years ago, this state was in the throes of a polio epidemic which struck down almost two thousand youngsters and adults alike. Medical and public health authorities—in fact the entire populace—reacted with grim determination and strong measures to combat the menace.

Still more recently, a flu epidemic overtook much of the state. Public reaction was immediate. Health officials, both private and public, launched a dramatic effort to prevent and relieve its spread.

Yet with a minimum of 500 to 2,000 identifiable cases of serious emotional disturbance among the young people of Wisconsin we have no suitable facility to cope with the problem. If this were a bodily disease, it is likely an epidemic state would be declared.

We cannot with conscience continue to mingle these youngsters with the frankly mentally ill in Mendota or Winnebago. It is no solution at all to merely house them at the Sparta Child Center.

We see these patients frequently in our practices. We know they need intensive care. We know the need for research to build our knowledge of the emotional disturbance. We know the need for more trained personnel. As physicians we must stand as a pillar of mental health and demand a treatment center to bring us at least one step closer to adequately dealing with a major public health problem.

Bill 3, S. will provide a 30-bed treatment center close enough to the University of Wisconsin Medical School and the Diagnostic Center to readily conduct research and training programs. The Medical Society, Medical School and Department of Public Welfare have agreed that the professional staff should be appointed by the Public Welfare Department with the advice of the Dean of the Medical School.

A $500,000 investment in a combined treatment-research-training unit will produce new and better techniques of treatment. But another important benefit will accrue to the public in the long term sense. We have known for many years that perhaps 50 per cent or more of the medical work of the general practitioner is directly concerned with mental health. Yet he is often less conscious of his key role in prevention and diagnosis of mental ills than with respect to diseases such as tuberculosis or cancer. The creation of a treatment center will provide innumerable opportunities for medical students to be trained in their mental health role. Through postgraduate education for the practicing physician the center will focus attention on his opportunity to do mental health work in his daily rounds with out-patients, school medical services, prenatal and premarital consultations and in contacts with nurses, social workers and others.

The legislature should approve Bill 3, S. as outlined above and legislators should urge its rapid implementation.

William B. Weldenhammer, M.D.

Old Injun Remedies

SECTION ON MEDICAL HISTORY

Back in 1816, the Menomonees around Green Bay were led by a Chief Tomah, known for his strength and wisdom. That year Col. John Bower, the Indian agent at nearby Fort Howard, was suffering cruelly from gout. From helpful Chief Tomah to Bower came a "very rational" prescription: ". . . drink no whiskey, live on lean meat, and wild rice, and *scarify* (the) feet."

* * *

It was in the fall of 1829 that Col. Zachery Taylor (later the 12th president of the United States), busily building Fort Crawford at Prairie du Chien, ordered an expedition to go down the Menomonee river to cut logs, hew square timber, make planks and shingles.

On the way, the small army party bumped into a war party of Chippewas looking for Sioux and trouble. The Chippewas meant no harm to the soldiers, but a certain Lieutenant Levin Gale took fright and fled into the woods.

Gale wandered for three days and nights in bitter weather. When he was finally found, the exposure had "deranged his mind and he did not recognize his friends." His feet and legs were frozen up to the knees.

The soldiers followed an old Indian remedy: a hole was cut in the river ice and the lieutenant's limbs were thrust through into the frigid waters. After the frost was out of the frozen parts, they were greased with melted deer-fat and wrapped up in blankets. "He endured great pain, for every motion was torture."

The expeditionary force started to make its way back to Fort Crawford when it came in sight of Indian lodges on Wa-ba-sha prairie. When Lieutenant Gale caught a glimpse of Indians again he became hysterical.

But Chief Wa-ba-sha himself took charge of Gale and applied a concoction of white oak bark and a poultice of roots to the poor officer's body. "To these remedies," says an old account, "Gale owed his perfect recovery, if not his life."

When Gale got back to the fort he was placed under the care of the military physician, Dr. William Beaumont, who later became internationally famous for his experiments on gastric juices.

* * *

The dried root of sweet flag was powdered and stuffed up the nose to cure catarrh. It was also one of the ingredients of a remedy to stop a hemorrhage. The formula: chips of the heartwood from a four-inch Ironwood; the heartwood chips of a four-inch Arbor Vitae; root of the sweet flag; and a handful of the root bark of the common shining willow. Placed in a vessel and covered with two quarts of water, the mixture was boiled down to a pint. One tablespoon of this was taken every hour until the hemorrhage stopped. It was described as bitter as gall, and was used generally by the Potawatomi.

* * *

Ginseng, highly valued among the Chinese, was also used by the Forest Potawatomi and others in the Wisconsin region. The Potawatomi would pound the root to make a poultice for ear ache. For sore eyes, the pounded root was soaked to obtain a wash. The Indians also used ginseng in many of their powdered medicines as a seasoner to mask the bad flavor of some other ingredients.

WANTED: Contributions for this page from readers. Your contributions would assure a continuous flow of material on medical history. Take a few minutes' time tonight and jot down one or more interesting stories you know, people and places in medical history, events that show early medicine in Wisconsin. Send us early photographs, too, if they are available.

National Hospital Week, May 10-16

The nation's hospitals, through the American Hospital Association, have invited their closest ally, the medical profession, to help them develop greater understanding and appreciation of their services and contributions to the American people.

This year's program, centered in a seven-day observance of National Hospital Week, May 10–16, will emphasize the theme of "More Roads to Recovery." An explanation of these "roads"—better care, improved techniques and skills, greater numbers of personnel to apply the dramatic successes of medical science—will help offset an impression that hospital costs are greater than the services received.

Such stories not only jeopardize public regard for the hospital but for the entire medical team, including the practicing physician. Consequently, it is to our mutual advantage to work together toward overcoming these detrimental impressions which are gaining some acceptance.

Through the use of public forums, tours of hospital facilities, talks to community groups, and radio, television, and newspaper facilities, the story of the unprecedented hospital services now available—resulting in shorter hospital stays, employment of all the medical advances, and healthier and longer lives—can be told convincingly.

"More Roads to Recovery" are the patient's reward for the close harmony and utilizations of the tools and skills of both the hospital personnel and the medical profession. These rewards can be made more meaningful by your participation in National Hospital Week.

Each physician in the community has a role and responsibility to win public support for the hospital in which he practices, and we urge you to offer your help to your hospital administrator and to your hospital association inasmuch as National Hospital Week, May 10–16, is an exceptional opportunity for creating greater appreciation of the entire medical team.

MD's Waive Fees

Isolated cases involving medics and fees make the headlines, but benevolent and humanitarian acts by members of the profession rarely do.

There may be truth in this complaint by a Kenosha physician, but, we submit, the fault, if any, lies with the medics themselves, a close-mouthed group if there ever was one.

It is a rare day when a medic volunteers information to the press about deeds beyond the call of duty, or providing medical care for which they expect no fee.

Doctors do play a great humanitarian role in the scheme of things, as witness their performance in the recent Chicago school fire.

Nearly a hundred youngsters and nuns lost their lives and scores of others were severely burned. Physicians in the four Chicago hospitals caring for the burned victims waived their fees to the children's parents. The contribution has been conservatively estimated at more than $150,000. And it could exceed $200,000 depending on the amount of long-term care required by some of the children.

This is indeed an act of generosity and kindness, a great contribution by Chicago physicians to the profession as a whole.

There is other good news on the side of the medical profession. The American Medical Association's House of Delegates has approved a proposal which calls for physicians to provide medical services at adjusted rates to persons over 65 years of age with reduced incomes and modest resources.

Specifically, the proposal asks insurance companies and medical prepayment plans to develop new policies at special low premium rates for people in this category. It further provides that if the income and resources of the insured fall below a specified sum, doctors would agree to adjust their rates accordingly.

Though we know of cases where medics have given their time and talents without thought of remuneration, this new plan is a big step in the right direction.

In a discussion of the medical profession it is also well to remember that today we are receiving a greater quantity and variety of services, as well as vastly improved quality.—Reprinted from *Kenosha Evening News*, January 16, 1959.

Pharmaceutical Advertising to Doctors Needs No Apology

Health service standards in the U. S. are the highest in the world. This is due both to national prosperity and a broad distribution of national income, and also to the great contributions made to public health by the medical profession, medical schools, hospitals, public and private research and the work of the pharmaceutical companies and others who provide the drugs, equipment and materials used in all phases of health service.

In view of this favorable picture, it is rather astonishing to find the medical profession and the pharmaceutical manufacturers under attack in a recently published book, "The Doctor Business," authored by Richard Carter, who is reported to have been employed at one time by the well-known pharmaceutical house of Charles Pfizer & Co., famous for research and development in the broad field of antibiotics.

The charges which Mr. Carter makes seem to be based primarily on the fact that advertising is used to bring information regarding new and improved drug products to the attention of the medical men, and that as a result the doctors prescribe these drugs in the treatment of their patients.

Just why this should be considered bad from the standpoint of the public, which benefits from the rapid dissemination of good news regarding improved medical products, is hard to understand. Apparently Mr. Carter disapproves of the part played in this process by the American Medical Assn., whose weekly *Journal* carries advertising volume totaling $4,000,000 a year. Because advertising of this kind is effective, as far as acceptance by doctors of new drugs is concerned, Mr. Carter castigates them as "shills" for the pharmaceutical industry.

The AMA of course has no monopoly of drug advertising, as there are hundreds of medical journals, and many of them are more than ordinarily successful in attracting advertising to their pages. In addition the pharmaceutical houses use a tremendous amount of direct mail, including house publications of exceptional quality in design and content, besides having detail men call on doctors to provide samples of new products and explain their applications.

Some medical men don't like to admit that they receive professional information from commercial sources. In fact, the *AMA Journal* has published articles by doctors who object to the amount of advertising of new drug products carried in the medical journals. But experience indicates that the majority find pharmaceutical advertising, most of which is highly factual in content, useful in pointing up the value of new drug products.

The introduction of a new drug is not automatic, as far as the AMA is concerned. Its Council on Pharmacy passes on all new drugs, and must approve them before they are acceptable for advertising in the association's journals. Obviously these new and better products are the result of large scale research, not only in the laboratories of the manufacturers, but clinically, since they are tested carefully and over long periods before being introduced to the medical profession generally. And they must pass the scrutiny of the Food and Drug Administration before they can be put on the market.

The drug companies contribute to the research work of universities and hospitals, both by outright grants and by contributions for research in specific fields. While the total amount of research done by the industry has never been calculated exactly, and varies widely from company to company, because of differences in type of operation, it is one of the largest factors in operating costs. It represents the constant effort of pharmaceutical manufacturers to develop and test new products which will aid in the successful treatment of the sick. Obviously it is a basic approach to market development and expansion.

Doctors want their patients to get well, and do all they can to expedite their recovery from illness. They use all of the modern aids to diagnosis, such as X-rays and laboratory tests, and they employ drugs, new and old, which seem to be indicated, along with physical therapy and other modern health services. In applying their professional knowledge to the treatment of disease, they are performing their jobs to the best of their abilities.

Does this make them "shills" for the manufacturers of new drugs, such as the sulfas and antibiotics which have enabled doctors to fight infections so much more successfully today than formerly? The doctor has no financial interest in the sale of the drugs which he prescribes, and his only concern is to use medications which will help the patient to get well faster.

It may be true, as Mr. Carter says, that sometimes penicillin and other antibiotics are prescribed when not absolutely necessary. Often doctors are importuned by their patients to use the newer "wonder drugs," which have been widely publicized, even when they are not absolutely necessary. But this is a problem in human nature.

Basically the research which develops new and better drugs and the advertising which makes them familiar to doctors represent a valuable service to the public. Certainly the generally improved health of Americans and the gradual extension of the life span of our population indicate that the service has been effective.

Mr. Carter can hardly be opposed to progress of this kind, even if he doesn't like organized medicine and would like to see the government play a larger part in the medical, hospital, and health services of the nation. This book may, in fact, be an indirect plea for socialized medicine.—G. D. Crain, Jr. (Reprinted from Advertising Age, December 1, 1958.)

THE MEDICAL FORUM

STATE AFFAIRS

CHIROPRACTIC

Little Black Box

The most bitter debate of the 1959 legislative session was waged one day last month over a little black box that appeared on the Assembly floor.

Replete with dials, switches, wires, radio tubes and a "heater", the little black box carried an enormous name: "Neurolinometer". It also carried the enormous prestige of the chiropractors of Wisconsin who desperately want Bill 133-A so that the injured, covered by workmen's compensation, can choose them for treatment at their employer's expense.

The little black box was "one of the nerve pressure detecting instruments in use" at the Toftness Chiropractic Clinic in Cumberland, Wisconsin, according to their booklet.

According to the detecting eye of the federal government, the device was "worthless in the diagnosis of disease", so federal authorities had the nerve to seize six such boxes in January, 1958, and pressure the Toftness people, who were mechandising them, into stopping "mislabeled" shipments across the state line.

But this was only after many of the machines had been helpfully sold to fellow chiropractors at a cost of $165, plus a $500 instruction course.

High pressures. The Assembly fight over 133-A blew pressures so high that no little black box was needed to detect them. Democrats (mainly from the Milwaukee-Kenosha area) generally supported the bill, but party lines on both sides were fairly well split.

It was when Assemblyman Elmer Genzmer (Rep., Mayville) stood up to attack that chiropractic nerves were touched to the raw. Opening the little black box, he displayed it to the curious legislators.

The dials "aren't even wired up to anything," he pointed out. He pronounced it "a piece of trash".

Clearly, his exhibition unnerved proponents of the bill, and there were protests that the "chiropractor is not going to hurt the workingman of Wisconsin . . . the American Medical Association wants protection. . ."

But Assemblyman Jerris Leonard (Rep., Bayside) continued the attack: "This little box is a fraud."

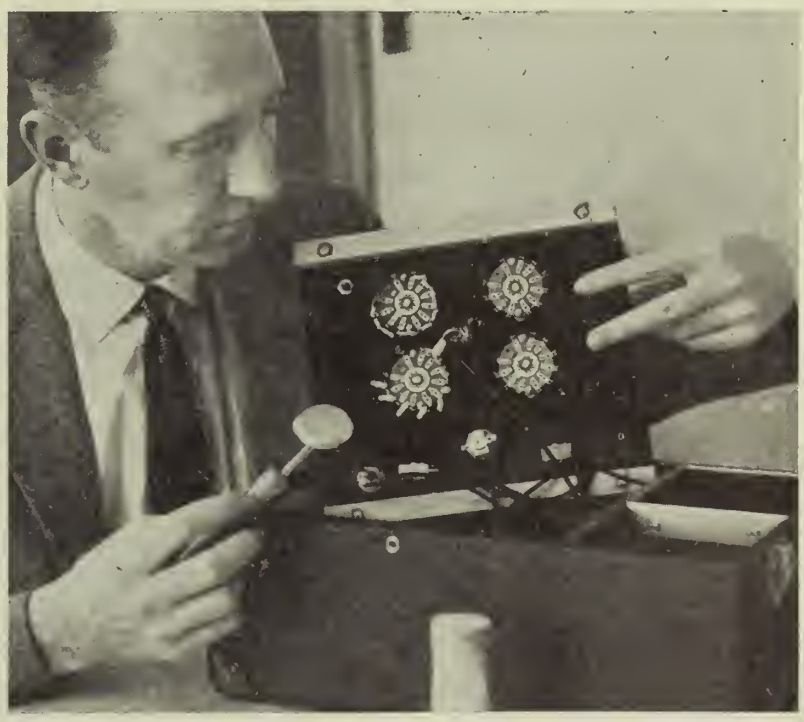
"Sordid scramble." Leonard read authoritative statements from physicians that persons treated by chiropractors risked injury to their health by delaying needed treatment.

Leonard thought he detected, . . . "a sordid scramble by the chiropractors to get their snoots up to the public trough . . . they have no interest in public health!"

But the Assembly on that day proved that chiropractors had done their backbone-bracing work in the home districts of legislators before coming to Madison. Amidst much manipulating and adjusting of sensitive nerves, the bill was given its first major boost toward passage by a vote of 55 to 39. It was sent to the finance committee and will again come up in the Assembly later.

While chiropractors had won another round in the fight, the little black box had so exposed certain matters that newspapers across the state were beginning to join the opposition.

The little black box device might yet become Pandora's Box for chiropractic.



"Toftness Neurolinometer," whose appearance during legislative debate on bill 133-A touched off a bitter struggle, is examined by Dr. R. G. Zach, Monroe Clinic. Doctor Zach's fingers point to two dials (labeled "Cervical" and "Base") which bore no evidence of being connected to anything. In his right hand Doctor Zach holds the device which was placed on patient's spine. Operator determined ailment when his fingers became "sticky" from rubbing against a plate on the machine.

"A bold, pioneer achievement . . ."

—Dr. E. M. Dessloch

CENTURY PLAN HEALTH INSURANCE

Wisconsin Physicians Service has announced a special health insurance plan which has been designed to meet the needs of Wisconsin citizens who are 65 years of age or older.

The insurance is known as the "Century Plan." It provides benefits for surgical, medical, hospital, nursing home and sanitarium care.

The Century Plan will be offered statewide on May 1, 1959. No policy will be issued before that date.

Anyone 65 years of age or older may enroll. Protection for those who are enrolled is effective immediately *except for:*

(1) Conditions for which treatment has been received during the past year;
(2) Or which existed on the effective date of coverage;
(3) Or any of the following: Appendix, Benign Tumors, Cystocele or Rectocele, Gall Bladder, Hemorrhoids, Indirect Hernia, Prostatic Condition, Uterus (including Ovaries and Tubes), and Varicose Veins.

However, benefits for such exceptions will be available after a nine month waiting period.

Monthly premiums for the plan have been set at $9.00 per person. There is no family plan.

Physicians' Services

1. Benefits for physicians' services are provided as follows:
   a. Surgical Services, wherever performed.
   b. In-Hospital Medical Services for patients admitted to a general hospital for up to 60 days for each illness for which hospital benefits are payable.
   c. Anesthesia Services, when associated with surgical services.
   d. Diagnostic X-Ray Services, when associated with surgical services.
   e. Radiation Therapy Services, for proven malignancies.

2. Benefits paid by Wisconsin Physicians Service according to the "B" schedule in effect at the time of the service rendered are to be accepted by participating physicians as full payment, if an individual's annual income is $2,000 or less, or a man and wife's combined annual income is $3,600 or less.

Institutional Care For Conditions Other Than Nervous and Mental

Hospital Benefits—for patients admitted to a general hospital

Hospital benefits are provided for the first 60 days of each illness. During this period, the Century Plan will provide up to $10.00 per day for room and board expense and 100% of miscellaneous hospital expenses.

Nursing Home Benefits

Nursing home benefits are available within the same 60 day period, but only when the patient is transferred directly from a general hospital to a nursing home, allowing a reasonable time interval for necessary travel. In such case, the Century Plan provides up to $10.00 per day for room and board charges, but not for miscellaneous expense.

Duration of Benefits

Hospital and nursing home benefits are limited to a combined total of 60 days per illness. However, if there is a period of 60 days between the date of discharge from a general hospital or nursing home and the date of the next admission to a hospital for the same illness, a new 60 day benefit is available.

Institutional Care For Nervous and Mental Illness

Wisconsin Physicians Service will pay only the room and board expense incurred for confinement in a general hospital, nursing home or sanitarium, up to $10.00 per day for a maximum of 60 days during the life of the subscriber. Again there must be a direct transfer (with reasonable travel time) from a general hospital in-patient confinement for immediate admission to the nursing home or sanitarium.

Miscellaneous Other Provisions

Out-Patient Hospital Benefits

Out-patient hospital benefits are payable for the first visit because of surgery or within 48 hours of injury.

Exclusions

The usual standard exclusions will apply.

DR. JAMES C. FOX

Who is going to practice?

SOCIETY SCENE

Council Meets

Meeting over the first weekend in April the Council issued a statement on the Wisconsin Insurance Department study of the Blue Cross and Blue Shield, which had been released the day before.

The report had called for closer state supervision of such insurance plans.

"A timely report," commented the Council, "which goes to the very heart of the health and insurance needs of the people of Wisconsin."

"Only the individual physician can be responsible for the personal medical care of the patient," declared Dr. J. C. Fox, chairman. "Thus we completely agree with the report from Insurance Commissioner Paul J. Rogan that the main issue is the question of who is going to practice medicine—the physicians or the hospitals."

"At the same time we commend Mr. Rogan's report for suggesting reasonable but realistic insurance department supervision of Blue Cross and Blue Shield plans—a position the Medical Society has endorsed for the past 20 years."

The issue. Dr. Fox recalled that in 1940 the Council declared:

"The issue has become whether medicine is to continue to be practiced *in* hospitals or *by* hospitals."

Pointing to the evils of lay control over medical care, the Council in 1940 cautioned that "medicine must and will insist on maintaining the principle that medicine shall be practiced to fill the needs of the individual sick patient, and not by subjugating patient rights to fill the needs of any institution or social insurance corporation."

Dr. Fox said the "same fundamental principles apply now, and we fully agree with the Commissioner that the paramount concern is the welfare of the patient."

Dr. Fox pointed out that the Medical Society has never sought exemption from supervision, and "the fact that Commissioner Rogan's report indicates the general financial soundness of Blue Shield in no way lessens our belief that supervision is desirable. . ."

Other Council matters included:

¶ Final study and approval of the Century Plan health insurance. (see story)

¶ News that Joint Resolution 42 of the State Legislature endorses the Society's Traffic Safety Stamp Campaign.

* Appointment of Dr. Raymond S. Hirsch, Viroqua, to the Wisconsin Commission on Medical Care Plans.

¶ Election of Dr. Erwin C. Cary, Reedsville, to honorary membership in the Society. Doctor Cary, 75, has been a regular member of the State Medical Society since 1910. During his distinguished career he has held many high posts, including that of speaker of the House of Delegates. Doctor Cary becomes one of only 13 persons now holding honorary membership.

ADOPTIONS

SMS Recommends

Prospective adoptive parents often resent personal health questions asked of them by adoption agencies.

To ease such objections, the Commission on State Departments, through its Division on Maternal and Child Welfare, has made two recommendations:

1) Each agency employ the services of a physician to serve as "medical consultant", and to assume the responsibility of receiving medical reports required, and on the basis of such reports to make proper recommendations to the agency without revealing specific information which would be of a confidential character.

2) That a simple form be devised (a sample was submitted) which would be filled out by the family physician of the applicant. This form would provide evidence on certain fertility tests required of applicants for adoptive children.

Adoption agencies will be urged to put both recommendations into effect as soon as possible.

CIVIL DEFENSE

Committee Meeting

At an April meeting of the SMS Civil Defense Committee, considerable time was spent revising a portion of the *Mobile Medical Team Manual.*

One realistic change: "On certain occasions the order of priority of treatment needs to be modified or changed. In the event that the disaster is due to enemy action, and invasion is eminent, high priority for treatment should be given to moderately injured key personnel who will be able to perform duty in resisting the enemy. Such personnel would include military personnel, civilian police, physicians, nurses, and persons engaged

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MILWAUKEE WISCONSIN

The following is an editorial from the March 21, 1959, Milwaukee *Journal:*

Keep Workmen Compensation Laws From Being Opened Up

Strong Democratic and some Republican support in the legislature behind a perennial pet bill of the chiropractors is causing much amazement. It should cause some deep blushes of shame and a quick change of direction.

The bill would permit a person injured in an industrial accident to draw workmen's compensation money, according to state regulation, for chiropractic treatments rather than treatment by a regular doctor of medicine.

The "free choice" argument, advanced by some of the bill's supporters, is strictly a phony. Under such reasoning, the state would have to be ready to approve payments for any kind of patent medicine, electric belts, magic beads, visits to medicine men or whatever any industrial victim chose to try—legal or illegal— in place of valid medical treatment. The State would then be utterly delinquent in its duty to both the public and the patient.

The purpose of enforced workmen's compensation payments for medical care in industrial accident cases is to assure proper treatment. It is not the matter of pleasing whims or catering to the idiosyncrasies of any victim.

The legislature shouldn't think of authorizing substitution of chiropractic treatments and would be utterly irresponsible to do so. The reasons for not doing so would be the same sound reasons why the veteran's administration won't pay for chiropractic treatments of disabled veterans.

The reasons would be the same as a Maryland court gave for not authorizing use of relief money for chiropractic treatments. That court commented that chiropractic practice was based "on a healing system and cult theory of one cause of disease and a panacea or near panacea in one treatment".

The chiropractors in Wisconsin have been aggressive politically. They have maintained a strong lobby in Madison. Some Democrats are said to welcome a chance to take a jab at doctors generally, because many doctors have supported the Republicans.

Even under such pressure and temptation, however, a legislator with any integrity doesn't play loose with the protection of unfortunate victims of industrial accident.

in communications or supply work."

The Committee wants to obtain from the AMA model legislative proposals to provide medical and paramedical liability immunity protection in the event of injury, both in training and in actual disaster situations.

Organization of emergency hospital beds is progressing, and the defense status of the seven-county unit in the Milwaukee metropolitan area is improving. Ozaukee was cited as the best organized unit in the area with Racine next.

Instruction for mass evacuation is based on: 1) If there is time, get outside of the direct target area and man evacuation centers; 2) If there is no time, *take cover*, and stay underground until major radiation hazard is over.

POLIO

Grave Threat

"Half of Wisconsin lies under the grave threat of polio," said Dr. William B. Hildebrand, president of the SMS, in a special news release late last month.

Prompted by public apathy and nation-wide estimates that only 42% of Americans under 40 have had one or more of their Salk shots, Doctor Hildebrand warned the state against "the alarming slowdown" to seek protection.

"Last year," he pointed out, "there was a shocking 43% rise (in the U. S.) in paralytic polio over 1957. In the Detroit area alone an epidemic raged, which left a toll of 867 polio cases and 23 deaths for 1958."

"Unless we can overcome apathy . . . we must expect a recurrence of polio epidemics throughout the country. Possibly one of them will happen in Wisconsin," concluded Doctor Hildebrand.

SURVEY

Character of SMS

Through the wonders of the IBM machine, the SMS now possesses a thorough analysis of the character of the medical profession in Wisconsin. The following is based on data as of November 1, 1958:

The SMS has 3,168 members. Largest of the 53 county societies is Milwaukee (1,097 or 34.6%), next is Dane (352 or 11.1%), then Racine (107 or 3%). Smallest county society is Juneau with four members.

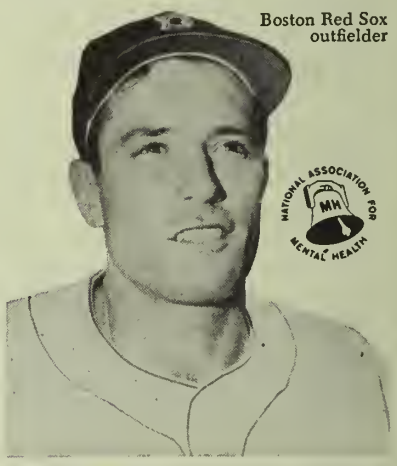
Oldest member of the Society is 91 (licensed in 1893), and the three youngest are 26.

Ages	Number	Per Cent
25–35	531	17
36–45	961	31
46–55	787	25
56–65	479	15
Over 65	410	12
	3,168	100

Schools of Graduation

Marquette University		956
Wisconsin	"	623
Illinois	Schools	610
Minnesota	"	94
Pennsylvania	"	103
New York	"	80

Boston Red Sox outfielder



The 1959 Mental Health Campaign (April 27-May 31) will feature testimonial from Jim Piersall, Boston Red Sox outfielder, as one who made the road to recovery.

For National Hospital Week AHA has invited its "closest ally," the medical profession to help develop greater understanding and appreciation of the nation's hospitals, their services and contributions to the American people.

Michigan	"	58
Iowa	"	54
Canadian	"	21
German	"	20
English	"	1
Chinese	"	1

In addition, 69 physicians were graduated from Milwaukee Medical College or the Wisconsin College of Physicians and Surgeons, Milwaukee, both now extinct.

Methods of Practice. Of SMS members, 1,648 (52%) practice individually, and another 1,042 (32.8%) are in some form of partnership or clinic practice. At the time of the survey, 273 were in military service. The remaining 478 were in teaching, veterans administration, public health, residency training, sanitaria or hospitals.

Type of Practice. Members were engaged in 37 types of practice:

Allergy	16
Medical Administration	8
Otology, Laryngology, Rhinology	27
Anesthesiology	61
Cardiovascular Diseases	19
Dermatology	43
Gynecology	5
Gastroenterology	9
General Practice	1,136
Hospital Administration	3
Internal Medicine	318
Industrial	27
Military & Government	10
Neurology	3
Neurological Surgery	14
Ophthalmology, Otology, Rhinology	99
Obstetrics	27
Obstetrics & Gynecology	164
Ophthalmology	70
Orthopedic Surgery	64
Psychiatry	63
Pathology	52
Pediatrics	103
Public Health	31
Plastic Surgery	15
Physical Medicine	5
Neurology-Psychiatry	40
Proctology	17
Pulmonary Diseases	23
Professor	2
Radiology	91
Residency	23
Research	1
Retired	38
Surgery	456
Thoracic Surgery	7
Urology	68

This data, plus substantial additional detail, promises to be of great assistance to the SMS, to medical education and to the public.

MISCELLANY

Drug Flood

According to the Health Information Foundation pharmaceutical authorities state that 70% of drugs in use today were not available 10 years ago, and 80% were not to be had 20 years ago.

Ads Add

Medical advertisers invested $27,620,000 in daily newspapers alone in 1957, an increase of 13% over the previous year, to tell the public about their products.

A recent news release from the American Nurses' Association again warned of an apparent commercial enterprise known as the American Registry of Doctor's Nurses. The SMS made its position on the ARDN known in the following letter to Miss Mary Dougherty, Wisconsin State Nurses Association:

"Our Committee (on Public Policy) reviewed in some detail reports we have received about the American Registry of Doctor's Nurses. As you probably know, this is a Mariana, Florida mail order operation. Within the past months, according to the American Medical Association, the ARDN was cited by the Florida courts as being in violation of the state nursing practice act. The organization has now moved its operation to Washington, D. C., where possibly laws concerning this type of operation are not as strict. All of the physicians whose names appear on the letterhead are licensed to practice in the state of Georgia.

"The members of our Committee on Public Policy wish to assure you that they are in complete sympathy with your problem with this group, and, of course, recommend that nurses in Wisconsin identify themselves with reputable Wisconsin groups such as the Wisconsin State Nurses Association. In addition, the State Medical Society and the American Medical Association have pointed out on several occasions that the only organization for doctors' aides which is closely identified with the medical profession is the Wisconsin State Medical Assistants Society and its national organization known as the American Association of Medical Assistants. As you know, this group is comprised of doctors' office aides and membership is open to one who is "actively employed by Medical Society of Wisconsin." We are publicizing the ARDN group to all physicians so that they might distinguish between the new organization and those that already have recognition."

PROFESSIONAL BUSINESS SERVICE
1204 State Street
La Crosse, Wisconsin

Business Consultants to the Medical Profession.

Inquiries Invited

STATE AFFAIRS

HYGIENE

State Lab Report

The Wisconsin State Laboratory of Hygiene is only six years old, but already it has made milestone progress in the early detection of disease.

Located on the University of Wisconsin campus, the Laboratory under its director, Dr. W. D. Stovall, has as its aim, "expanded programs of diagnosis, intensified studies of infectious diseases and improved health for citizens of Wisconsin."

Laboratory specialists last year conducted nearly 770,000 examinations of specimens sent in by physicians, public health officials, and nurses, public institutions, restaurants, hotels and others.

Technicians searched for diseases ranging from virus pneumonia to cancer.

Exploring new areas is one of the laboratory's duties, and the use of the Papanicolaou smear for early detection of cancer in women is just one example.

BROWN COUNTY

Rehabilitation

Some months ago the State Board of Health announced that Brown County had been selected to conduct Wisconsin's new demonstration program on care of the aged and chronically ill in nursing homes.

The pilot program, now under way, is operated on federal funds, uses local physicians and physical therapists with group care experience. The plan is voluntary and involves intensive work with each patient.

The first results, covering roughly six months, are now in. To date, 16 area physicians have practiced rehabilitation in seven local nursing homes, giving up to 18 patients a total of 114 treatments in a month.

"The program is definitely promising," said Dr. Carl Neupert, State Health Officer, "and the potential is there for even more."

Example:

A 69 year old woman had suffered a stroke six months previously with resulting right hemiparesis. When first seen, this patient could walk a short distance with much assistance and could transfer from bed to wheel chair alone. Her accomplishments to date include independent ambulation, use of both tub and toilet facilities unassisted, complete dressing of herself, and the beginning of hand activities for recreational purposes.

DR. WILLIAM D. STOVALL

Milestone progress . . .

MEETINGS

Medical Assistants

Wisconsin State Medical Assistants' Society will hold its annual meeting in Eau Claire, June 6–7.

The 350-member organization will have a two day educational program, which will include a tour of Northern Colony.

Registrations may be made with Miss Violet Owen, 1922 University Ave., Madison.

DR. CARL N. NEUPERT

. . . promising programs . . .

NATIONAL

CIVIL DEFENSE

When the Banshee Wails

A tiny detector, called the Banshee, has been developed to plug into a standard radio or television set as an alarm against dangerous concentrations of radioactive fallout.

Operating through the loudspeaker, the Banshee's wail rises and falls depending upon the amount of radioactivity present. With a portable or automobile radio at hand, a person need only travel in the direction which causes the wail to fall to escape from a danger zone.

ARMED FORCES

Medical Packet

A new emergency medical treatment packet, designed for first aid and advanced treatment when no direct professional medical help is available, has been developed by the U. S. Army.

The packet of 23 items is divided into nine parts: two master packs, one containing destran and miscellaneous items, one fracture pack, two burn packs and four wound packs.

The packet will treat approximately 100 casualties for about 72 hours.

FOOD ADDITIVES

Burden of Proof

For years the federal government, policing the nation's food additives regulations, has been hampered by the common law concept that all is innocence until proved guilty.

Applying that concept to food additives meant the government had to prove a particular chemical used in food was unsafe. Trouble was that legal action took place only after a food item was already on the grocery shelves.

Last month the burden of proof shifted. Governmental authorities are now armed with a healthy new directive: a chemical intended for use in foods must be proved safe by industry before it can be added to a food and sold to the public.

AFFAIRS

AMPHETAMINE

Teen-Age Twist

Troubles with amphetamine go back almost 20 years to a time when it was used in a popular nasal inhaler.

The inhaler became even more popular when it was discovered by prison inmates that its paper fillers, loaded with 250 mg. of amphetamine, could produce a monumental jag when chewed.

The manufacturer found a better decongestant, propylhexedrine, and dropped amphetamine from its tubes. But recently amphetamine found its way into another maker's inhaler, and the old trouble began again.

Teen-agers became the new users and with a new twist: hot water slushed around in the inhaler, then injected into the arm with a hypodermic needle.

Kansas City (Mo.) police, after a recent rash of robberies, holdups and muggings, estimated at least 600 users within its environs, and law enforcement officials across the land have experienced similar numbers.

Last month the Food and Drug Administration announced an order that forbade the selling of amphetamine laden inhalers without prescription.

ARTHRITIS

Treatment Centers

A new nationwide network of treatment and evaluation centers for aiding millions of American arthritis and rheumatism sufferers has been announced by the National Foundation (originally "for Infantile Paralysis").

The regional centers, one of which is already in operation, will be a new approach to the arthritis problem, according to the Foundation. It is estimated that upward of 11 million in this country are afflicted with the disease.

The Foundation expects to open several of the new centers this year with more going into operation by 1960. Services at the centers will be available to physicians throughout the U. S. Out-patient treatment will be offered primarily.

The annual March of Dimes will support the arthritis centers.

GLAUCOMA

I. D. Cards

Newest of the emergency identification cards for patients is one for glaucoma.

Distributed as a public service by the National Medical Foundation for Eye Care, the card is similar to others, alerting examining physicians that drugs are being used for treatment.

The names of the patient and of the ophthalmologist who prescribed the drugs appear on the card, together with the prescription.

Glaucoma patients who run out of their prescribed medicine while away from home are able to get a new supply quickly, without interrupting treatment, an important factor in glaucoma therapy.

DR. HARRY E. KASTEN

. . . and outstanding individuals.

POLIO

Legislation

As the *Medical Forum* went to press word was received that North Carolina became the first in 49 states to pass legislation requiring vaccination against polio.

The new state law will cover all pre-school children (2–6). The only exceptions will be granted to those whose religions forbid it. The state will pay for indigent children.

House of delegates in both Pennsylvania and Ohio have voted to support similar legislation.

SYPHILIS

On the Rise

The number of syphilis cases in the United States rose last year from 131,763 in 1956 to 136,039, according to a report issued by the Public Health Service in November.

BOOKS

Who's Who

The editors of *Who's Who* have informed the SMS of the addition of two Wisconsin physicians to the next volume (31st) of that distinguished publication: Dr. H. E. Kasten, Beloit, immediate past president of the SMS, and Dr. Clinton N. Woolsey, the Charles S. Slichter Foundation Research Professor of Neurophysiology, University of Wisconsin.

In selecting its list of the nation's outstanding individuals for publication, *Who's Who* is generally credited with doing a good job. A non-profit foundation, it resists all attempts of "buy space" within its pages, and it contacts the individual to be included, not the other way around.

The following is a list of Wisconsin physicians appearing in the current volume of *Who's Who:*

Dr. R. F. Wilson, Beloit, Dr. E. H. Hudson, Cedar Grove, Dr. Gunnar Gundersen, La Crosse, Drs. D. M. Angevine, H. D. Bouman, J. Z. Bowers, O. A. Mortensen, O. S. Orth, L. A. Osborn, E. A. Pohle, H. H. F. Reese, W. B. Youmans, W. J. Bleckwenn, R. E. Burns, J. W. Gale, A. S. Jackson, O. O. Meyer, F. E. Mohs, E. R. Schmidt, W. A. Werrell, Madison,

Drs. Harry Beckman, W. J. Egan, H. R. Foerster, F. H. Haessler, W. P. Blount, R. S. Cron, C. W. Eberbach, J. L. Garvey, R. T. Gilchrist, A. T. Holbrook, Michael Kasak, F. D. Murphy, M. G. Peterman, Milwaukee.

Medical Writer's Guide

The January issue of the *Mississippi Valley Medical Journal* is the annual American Medical Writer's Association number.

The special edition contains papers read at the 15th annual meeting of the AMWA in Chicago last September, plus the three winning papers in the 1958 essay contest. There are some 40 original contributions and reports on many aspects of medical communications, including papers given at the Writer's Association annual workshop.

Copies of the 72-page reprint are available from the AMWA, WCU Building, Quincy, Ill., for 50¢ postpaid.

COMMUNISM

Strictly From Hungary

Communist Hungary tightened the screws with another twist to control medical doctors and clamp down on private practice.

A new decree, adopted at a council of ministers meeting, stated in a preamble that a law was necessary "to liquidate a large remnant of capitalist behavior".

Private practice will be permitted only by doctors who also have regular state jobs (thus those who are in current "favor"), such as a position in a clinic or hospital.

ECONOMICS

TAXES

This Above All . . .

The Tax Foundation, Inc., lists the amount of time it takes an average working man (a typical $4,500 year man) to pay for various items or necessities of living. The breakdown shows how little time he must work to pay for medical care, but how much longer he must work to pay his taxes:

Taxes	2 hours 29 minutes
Food	1 hour 39 minutes
Housing	1 hour 25 minutes
Clothing	37 minutes
Transportation	42 minutes
Medical	24 minutes
Recreation	20 minutes
Other	24 minutes
Total	8 hours

U. S. GOVERNMENT

Open for Loans

In a report issued late in January the federal government announced that its Small Business Administration will now provide financial assistance to privately-owned and "operated-for-profit" hospitals, convalescent and nursing homes, medical and dental laboratories.

The loans may be used for expansion, improvements and working capital.

To be eligible, a hospital must not exceed 100 beds (excluding cribs and bassinets) and a convalescent or nursing home or laboratory (not operated in conjunction with a hospital) must not exceed $1 million in annual receipts. A laboratory can also be considered if it is operated in connection with an eligible hospital.

A loan can go as high as $350,000 and even higher if a bank participates in making money available. Maximum maturity of a SBA business loan is 10 years, generally repayable in regular installments. Interest (5½% on a direct SBA loan or on SBA's part of a participation loan) is charged only on the actual time the money is outstanding. There are no penalty clauses for early repayment.

To qualify for federal assistance, the applicant must show that needed financing is not otherwise available on reasonable terms, that the loan can be repayed out of earnings. Collateral is required, along with certain minimum professional health standards.

Further detailed information on loans may be obtained from the regional Small Business Loans office by contacting Robert W. Davin, Branch Manager, 313 New City-County Bldg., 210 Monona Ave., Madison.

Good News About Our Life Insurance Plan!

Substantial dividends have been declared for payment at the end of the second year on policies at most issue ages.

All State Medical Society members under age 45 (nearest birthday) now qualify for insurance upon application without evidence of insurability even though their prior application may have been declined.

The age group 45 to 54 is reasonably close to meeting requirements for automatic coverage.

Premiums may now be paid on a semi-annual as well as on an annual basis.

Term insurance may be renewed for successive five year periods as of attained ages 54 or under.

The Plan will be re-opened for enrollment from April 15 to June 15.

You will receive an application form and more details by mail.

Benefits are underwritten by Bankers Life Company under the supervision of Seefurth and McGiveran Consulting Services, 783 North Water Street, Milwaukee 2, Wisconsin.

THE WISCONSIN MEDICAL JOURNAL

Volume 58 MAY 1959 Number 5

Listeria Monocytogenes Meningitis

Report of Two Cases

By J. H. HOUGHTON, M. D.

Wisconsin Dells, Wisconsin

LISTERIA MONOCYTOGENES was first submitted as a new species in 1924. The first authenticated case of meningitis due to this organism was reported by Burns in 1935. Prior to 1952, only twenty cases of listeria meningitis were reported in the literature.[1-6] Since 1952, eleven additional cases of listeria meningitis have been reported in the United States, and one case of subacute bacterial endocarditis. It may affect infants or adults.

Report of Cases

Case 1—This 58-year-old white male was first seen in my office on June 24, 1957. His illness had started two days previously with a feeling of severe chilliness and headache, both of which symptoms persisted. On June 24, he had three episodes of projectile vomiting and the headache became more intense.

Past history included pneumonitis in January, 1957, which cleared entirely by the middle of May. In 1952, he had a subtotal gastrectomy for a benign stomach ulcer with obstruction. He also has a hemolytic anemia.

On physical examination, his temperature was 104.6 F., pulse 100, and blood pressure 204/96. He was conscious but semistuporous, and answered questions with difficulty. There was marked rigidity of the neck. The pupils were constricted but regular. Abdominal and patellar reflexes were present and equal. Babinski was not elicited.

A diagnosis of meningitis was made and the patient hospitalized. Blood count showed 9.75 gm. hemoglobin, 2,900,000 red blood cells and 12,250 white blood cells. The urine was not remarkable except for a heavy trace of albumin and 4 plus urobilinogen. A spinal tap revealed a cloudy fluid under 48 cm. H_2O pressure. The globulin was 4 plus, total protein 14.5 mg. per cent, sugar 305 mg. per cent, and white blood cell count 1,100 with polymorphs predominating. The fluid was cultured. Since the direct smear showed what appeared to be cocci, the patient was placed on sulfadiazine and given 500 cc. of blood. Daily blood counts were taken because of the hemolytic anemia, and blood given as indicated. The patient did not improve on this medication. When the results of the sensitivity studies were available, he was put on chloramphenicol, 500 mg. every six hours and nystatin, 500,000 units every eight hours. On this regimen, his temperature gradually dropped to a level of 100 F. by June 28 with associated clinical improvement. However, he did not improve beyond this point; and on July 1 his temperature rose to 102 F. and he developed a severe headache again. Consequently, on July 2, chloramphenicol and nystatin were discontinued and he was placed on tetracycline and nystatin, 500 mg. every six hours. The temperature rapidly dropped to normal, and the abnormal signs and symptoms disappeared. He was discharged on July 10 and has remained well with no residuals.

The culture of the spinal fluid showed gram-positive rods which the laboratory at the local hospital was unable to identify. A culture was sent to the Wisconsin State Laboratory of Hygiene at Madison where the organism was identified as Listeria Monocytogenes.

Case 2—This 74-year-old white male was first seen at his home on June 27, 1957, with a complaint of severe headache and weakness. Past history was negative except for Parkinsonism which had been present for the past three years.

On examination this man was lying in a position of extreme opisthotonos and he was semistuporous with a temperature of 103 F. The neck was rigid as well as the back. The other reflexes were not unusual. He was hospitalized and a spinal tap done. The fluid was clear with a pressure of 22 cm. of H_2O. The cell

count was only 7. A culture was done and a growth was obtained in two days which was described as gram-positive rods, the same as seen in case 1.

The blood count picture was as follows: hemoglobin 15.8 gm., red blood cell count 5,300,000 white blood cell count 8,700, stabs 33, segs 49, lymphocytes 5, and monocytes 13. His sedimentation rate was 26 mm., and the urine was negative.

As a result of our experience with case 1, the man was put immediately on chloramphenicol, 500 mg. every six hours, and nystatin, 500,000 units every eight hours. Parenteral fluids and sedation were given as needed. His temperature dropped to normal on the third hospital day, and he was discharged on July 10. He has remained well with no residuals.

TABLE 1

Antibiotic	Case 1	Case 2
Novobiocin*	S	S
Bacitracin		S
Carbomycin		S
Chloramphenicol	S	S
Chlortetracycline		S
Dihydrostreptomycin and streptomycin	S	S
Erythromycin	R	S
Neomycin		S
Oxytetracycline		S
Penicillin		S
Polymyxin B	R	R
Sulfadiazine, triple sulfa, or acetyl sulfisoxazole**	R	S
Tetracycline	S	S
Viomycin		S
Oxytetracycline***	S	

S—Sensitive
R—Resistant
*(Cathomycin, Merck)
** (Gantrisin, Roche)
***(Terramycin, Pfizer)

Comment

Listeria Monocytogenes is commonly found in animals, such as sheep, cattle, swine, goats, dogs, horses, chickens, canaries, rats, guinea pigs, foxes, and ferrets. When found in the human, it is usually recovered from the cerebrospinal fluid. It apparently has a low degree of communicability. The portal of entry in the human is obscure, but most likely is through the nasal and respiratory route, and possibly through the gastrointestinal tract. It is thought that the organism is present, in the human, more often than realized since it morphologically resembles the Corynebacteria and the diphtheroids and, for this reason, may be considered a contaminant and its true identification overlooked. It may also be confused with a beta-Streptococcus and again be considered to be a contaminant. All diphtheroids isolated from spinal fluid should be tested for motility on semisolid medium incubated at room temperature. If motile, the organisms should be tested for virulence in mice and rabbits, and serological identification done.

Sensitivity to the various antibiotics and sulfa drugs varies, but as seen from the studies done on the above two cases and from reports in the literature, the organism is usually sensitive to several antibiotics. (Table 1). In case 1, the organism apparently became resistant to chloramphenicol but was sensitive to tetracycline. It is interesting to conjecture whether, in case 1, the preceding pneumonitis had any relationship to the subsequent meningitis. Unfortunately, no bacteriological studies were made on the pneumonitis.

Summary

The literature on Listeria Monocytogenes meningitis is reviewed and two new cases are reported.

Dells Clinic.

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Surgery In Disasters*

By ROALD N. GRANT, Captain, MC, USN**

St. Albans, New York

MR. CHAIRMAN, MEMBERS of the Phi Beta Pi Medical Fraternity, and guests. I am highly honored, as is the service which I represent, by this opportunity to participate in this 31st Annual Phi Beta Pi William Snow Miller Lectureship, on the centenary of his birth. The fundamental anatomical studies of the lung made by William Snow Miller are well known to thoracic surgeons throughout the world, and as a surgeon I am very pleased at this opportunity to pay tribute to him. The University of Wisconsin and its alumni may take great pride in his association with the university, being part of the great line of distinguished anatomists who flourished here—Doctors Bardeen, Sullivan, Bast, Mosman, and others.

The subject, *Surgery in Disasters*, is so broad that marked limiting is required. I propose to discuss our role as physicians in disasters and some of the factors which influence us in our work under such conditions. Disasters may result from a small explosion, an airplane crash, a railroad accident, a tornado, or the extreme devastation of our cities from nuclear warfare. Concerning the latter possibility, it should be stated that our country must be prepared to react and recover from attack by any force or weapon which any nation in the world has the capacity to employ against us regardless of what its current intentions or political affiliations may be. Since at least one nation on this earth already has the capacity to inflict mass destruction and disaster upon our cities, we must be prepared to cope with such conditions. Planning estimates for nuclear explosions calculate that for every 10% of destruction of real estate, 20% of the community become casualties.[1] Our role as physicians before, during, and after such disasters is obvious. In addition, we have the continuing responsibility of being prepared to meet disasters of lesser magnitude, such as tornadoes and catastrophies in our own communities. Every state in the union has experienced the destructive force of a tornado. Our state of medical preparedness for civilian defense cannot be permitted to fluctuate with the weather or each diplomatic success or failure.

What is different about medical care as performed routinely in our communities, compared with disaster conditions?

The characteristics of disasters which adversely affect medical care are the:

(1) *Suddenness, unfamiliarity and magnitude* of the devastation.

(2) *Shortages of equipment and materials* due to destruction and loss, and excessive requirements. For example, it is estimated that the transfusion requirements for 1,000 surviving casualties are 1,500 units of whole blood, 1,100 units of dextran and 400 units of blood derivative (albumin or plasma).[2]

(3) *Overwhelming number of casualties* which exceed, to the extreme, the available space for treatment, and the capacity of the medical and paramedical personnel to care for them.

(4) *Panic*, as it affects those who are to administer medical care as well as those who are to receive it.

These adverse effects can be diminished by the following methods (note that it is a pentology of "P's"):

(1) PLANNING AND PROCUREMENT of facilities and supplies. The plans must be flexible, but any plan is better than none. Materials and supplies must be stockpiled.

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* Thirty-first Annual William Snow Miller Lecture delivered at the University of Wisconsin, Madison, on March 20, 1958, under the auspices of Phi Beta Pi Medical Fraternity.

** Chief of Surgery, U. S. Naval Hospital, St. Albans, New York.

The opinions or assertions contained herein are private ones of the writer and are not to be construed to be official or reflecting the view of the Navy Department or the Naval Service at large.

(2) PERSONNEL PLACEMENT. Dynamic leaders must be appointed before the disaster occurs. There must be echelons of responsibility. Authority must be delegated broadly.

(3) PRACTICE. One drill will eliminate at least 50% of the confusion and uncover many of the deficiencies of the plan.

(4) PATIENT PRIORITY SORTING, OR TRIAGE. This is the first and supreme function of physicians in disasters. It is a continuous process which is carried on from the first physician on the scene until definitive care has been rendered. Sorting enables the community to preserve its strength and balances the medical needs with the means. It must be humanitarian as long as possible.

(5) PANIC PREVENTION. Panic is one of the most communicable conditions affecting man. The so-called "role personnel"—that is, those having preassigned duties or a mission to carry out in disasters (such as firemen, policemen, physicians, nurses, and so on)—are not permitted the luxury of panic. An understanding of the pathogenesis of the conditions will help us to resist and overcome this paralyzing process.

Because of their unique importance to physicians, the last two measures—patient sorting and panic prevention—merit further consideration.

Patient Sorting (Triage)

The purpose of patient sorting is to initiate and maintain the orderly flow of casualties and also to institute immediate lifesaving treatment. Further, it attempts to balance capacity with demand. For planning purposes, allowing for percentile variation, casualties may be sorted into four general groups.[3]

(1) Those needing *immediate treatment*, representing 20% of the total group. Arrest of hemorrhage, provision of airways, closure of sucking chest wounds, etc., is required.

(2) Those requiring only *minimal treatment*, representing 40% of the group. A minor dressing or nothing suffices.

(3) Those requiring *delayed treatment*, making up 20% of the total. Operative care such as laparotomies, thoracotomies and so on, is required.

(4) Those for whom only *expectant treatment* is possible, making up 20%. These patients are in extremis and only palliative care is possible.

Patients may be sorted at a maximum rate of 60 patients per hour, per triage officer. To accomplish this, he will need a large staff of paramedical personnel to administer treatment to the 20% of casualties who require immediate treatment, and the necessary clearing of the area of the 40% needing minimal treatment, and the 20% requiring only expectant treatment, leaving only the 20% who require operative care. For the latter group, the sorting officer has certain surgical criteria upon which to base his decisions, as follows:[4]

Surgical Criteria for Delayed Treatment Patients

Thoracic Wounds

Permissible Time Lag—12 hours (7% mortality rate under 12 hours; 30% over 12 hours)
Usual operation—Aspiration, closed thoracotomy, and dressing
Average operating time—1.6 hours
Case rate—20 patients per general surgeon per 24 hours

Abdominal Wounds

Permissible Time Lag—24 hours (mortality 23% under 24 hours; 31% over 24 hours; case fatality rate increases 0.5% per hour delay)
Usual operation—Laparotomy
Average Operating time—2.4 hours
Case rate—9 laparotomies per general surgeon per 24 hours

Soft Part Wounds

Permissible Time Lag—48 hours
Usual operation—Débridement and dressing
Average operating time—1.6 hours
Case rate—15 per physician per 24 hours

Orthopedic Wounds

Permissible Time Lag—48 hours
Usual operation—Débridement and immobilization
Average operating time—2.4 hours
Case rate—10 cases per orthopedic or general surgeon per 24 hours

Vascular Injuries

Permissible Time Lag—12 hours
Usual operation—Arterial anastomosis
Average operating time—3 hours
Case rate—8 patients per general surgeon per 24 hours

Brain and Spinal Cord Injuries

Permissible Time Lag—48 to 72 hours
Usual operation—Craniotomy
Average operating time—4 to 6 hours
Case rate—4 patients per neurosurgeon per 24 hours

Maxillofacial Injuries

Permissible Time Lag—24 hours or more
Usual operation—Débridement and primary suture of the wound
Average operating time—2 to 4 hours
Case rate—10 patients per general surgeon per 24 hours

Burns

Depending on the type of disaster, the treatment of burns may represent the largest medical problem to be solved. In situations in which there are large numbers of burn patients, their care will become the responsibility of internists and general practitioners since the treatment will consist primarily of fluid and electrolyte replacement and the *open* treatment of the burned areas. Under other conditions, such as those in which the casualties must be transported out of the area, the burned areas will be treated and dressed. The sorting criteria will then be as follows:

Closed Burn Treatment Program

Permissible Time Lag—Up to 48 hours
Usual operation—Débridement and dressing
Average operating time—1.6 hours
Case rate—15 patients per general surgeon per 24 hours
Patients with—10% OR LESS SURFACE AREA BURNS, treat ambulatory with little or no dressing care
—10 TO 20% SURFACE AREA BURNS, require hospitalization
—20 TO 70% SURFACE AREA BURNS, immediate full fluid and electrolyte therapy
—70%-PLUS SURFACE AREA BURNS, palliative delayed care only

Panic

Panic will now be considered in some detail because it often affects medical personnel so markedly that, under its influence, an entire medical operation in a disaster can bog down. A classic example, on a small scale, was the experience of a small city in the wake of a tornado.[5] When the casualties began arriving at the hospital the surgeons immediately commenced suturing the wounds, often enclosing the devitalized tissues and foreign material present. So many were busily sewing, and not thinking clearly, that casualties piled up at one hospital to await many hours for the dubious privilege of having their wounds so treated, while other hospital facilities stood available and unused. These competent physicians had succumbed to panic and were temporarily in a submissive, ineffective condition. In Korea, a young medical officer, qualified in a surgical subspecialty, found himself at a front-line battle dressing station. He had been there only a few hours and was somewhat concerned about his personal safety and the possibility of capture when four GI's appeared, carrying a dying comrade with multiple extreme wounds of the entire body. At a glance, the young medical officer could see he was in extremis and that there was little that could be done. However, his own insecurity of the moment, coupled with the sight of the patient's terrible wounds, caused him to become a victim of panic. He turned, walked into his tent, returned with a camera, and was about to photograph the dying youth when the four GI's succumbed to panic and started toward the medical officer, being restrained only with difficulty by bystanders. The medical officer had to be removed from front-line duties and assigned in a remote rear area position. We can sympathize with this unfortunate young physician for this unnecessary, degrading experience and the damaging blow to his ego. Had he understood, and been drilled against, the paralyzing effects of panic, he would automatically have set about dressing and covering the wounds. Soldiers are drilled to keep firing their weapons without thought when all is chaos around them!

The inability to take effective action in an emergency, under stress (as in a disaster), due to panic is very common. Only approximately 25% of the people have the innate ability to take appropriate action in extreme emergencies.[6] The remaining 75%, under the influence of panic, become totally ineffective due to extreme excitement, or more commonly, docility and stupor. (Table 1).

TABLE 1—STAGES OF FEAR

Mira and Meerloo	G I Term	Cortical Control
Prudence Concentration	Playing it cool	Highest level
Apprehension Anxiety	Being shook	Partial inhibition
Panic Terror (return to earth)	Going ape	Basal center control

Increasing fear causes partial inhibition of the higher cortical functions, much like the effect of anesthesia, proceeding from the highest levels to the lower brain centers. Mira[7] and Meerloo[8] classified the developmental stages of fear as proceeding from the first stage when the highest cortical controls are still effective, as prudence, concentration and apprehension. At the front lines in combat, this was known to the GI's as "playing it cool." In the next stage there is partial inhibition of the higher levels of the cortex. *Apprehension* and *anxiety* are the symptoms. The combat troops' term for this condition is "being shook." Finally, when there is complete inhibition of the higher cortical centers and control is taken over by the basal centers, a state of *panic* and *terror* occurs. The GI's term for this is "going ape." In this condition, there may be a stampede or more commonly a state of stupor and complete passiveness. The word, terror, is believed to be derived from the word terra, meaning return to earth. An unforgettable account of this type of degradation to ineffectivity by a physician under great stress is found in John Hersey's "Hiroshima."[9] I would like to read a paragraph which depicts the physician's experience.

"Doctor Sasaki worked without method, taking those who were nearest him first, and he noticed soon that the corridor seemed to be getting more and more crowded. Mixed in with the abrasions and lacerations which most people in the hospital had suffered, he began to find dreadful burns. He realized then that casualties were pouring in from outdoors. There were so many that he began to pass up the lightly wounded; he decided that all he could hope to do was to stop people from bleeding to death. Before long, patients lay and crouched on the floors of the wards and the laboratories and all the other rooms, and in the corridors, and on the stairs, and in the front hall, and under the portecochere, and on the stone front steps, and in the driveway and courtyard, and for blocks each way in the streets outside. Wounded people supported maimed people; disfigured families leaned together. Many people were vomiting. The people in the suffocating crowd inside the hospital wept and cried, for Doctor Sasaki to hear, "Sensei! Doctor!," and the less seriously wounded came and pulled at his sleeve and begged him to go to the aid of the worse wounded. Tugged here and

Fig. 1—Portable surgical hospital for civilian disasters. (Reprinted with permission from Mawrence, M., *Modern Hospital*, 1958)

there in his stockinged feet, bewildered by the numbers, staggered by so much raw flesh, Doctor Sasaki lost all sense of profession and stopped working as a skillful surgeon and a sympathetic man, mechanically wiping, daubing, winding, wiping, daubing, winding." (Of 150 doctors in the city, 65 were killed and most of the rest were wounded. Of 1,780 nurses, 1,654 were dead or too badly hurt to work. In a city of 250,000, nearly 100,000 had been killed; 100,000 more were casualties.)

In Korea, under the stress of receiving large numbers of casualties at one time, some triage officers underwent the same type of disintegration.[10] They wandered around amongst the casualties, aimlessly looking at medical tags, palpating limbs, and never making a decision or taking effective action. This occurred regardless of the age or specialized training which the officer might have had.

These paralyzing effects on our key personnel can be mitigated somewhat by insight and prior understanding of the phenomena. Training and experience will also help. The almost nightly disasters in London during World War II bombings were met with calm efficiency by the entire population after their first experience.

Medical Stockpile for Disasters

To assist us in providing medical care in disasters, the Federal Government has expended funds generously. For example, it has stockpiled throughout the United States, 2,000 200-bed portable surgical hospitals, similar to the Mobile Surgical Hospital uti-

Fig. 2—Beds of portable surgical hospital set up for disaster care. (Reprinted with permission from Mawrence, M., *Modern Hospital*, 1958)

lized so successfully in Korea. They are capable of making first-class medical care available on a large scale, under disaster conditions, if properly manned. The medical profession must assume responsibility for such staffing. Supplies and equipment for the portable surgical hospitals are provided to maintain 36 to 48 hours of operations.

Figure 1 is a photograph of one of these hospitals packed in 150 cases. It is easily transportable to a vacant building or school and set up as a hospital as shown in figure 2.

Summary

In summary, the never-ending threat of destruction of our communities by natural and military disasters demands a medical preparedness program which will enable us, as physicians, to meet our moral and patriotic medical responsibilities. Measures to diminish the impact of disasters on medical care have been enumerated, with emphasis upon patient sorting (triage) and panic prevention in medical personnel. Criteria and data to assist the triage officer have been presented. The anatomy of fear has been outlined, to mitigate through insight and understanding the paralyzing effect of panic on the 75% of physicians who may be expected to fall victim to it in disasters. Examples of life-saving surgery have been shown being performed efficiently under disaster conditions in facilities and with the type of equipment which has been stockpiled throughout the nation. Confident—and inspired by advance preparation and practice—we will be able to give our communities a high quality of medical care when "D" (disaster) Day arrives.

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SYSTEMICALLY ADMINISTERED HYDROCORTISONE PRODUCED a favorable response in each of 4 cases of hidradenitis suppurativa. This condition probably is a variant of cystic acne involving the apocrine glands. There was a steady regression of the lesions during treatment with only hydrocortisone. The patients were started on daily doses of 60 or 80 mg., and then after 1 or 2 weeks the daily dose was reduced. Hydrocortisone treatment was continued until the lesions disappeared or were well healed; this took from 15 to 57 days. Each patient was observed for a year after completion of hydrocortisone therapy, and in no case was there a recurrence.—Danto, Julius L.: Preliminary Studies of the Effect of Hydrocortisone on Hidradenitis Suppurativa, J. Invest. Dermatol. 31:299–300 (Dec.) 1958.

Applications for American Board of Obstetrics and Gynecology

Applications for certification (American Board of Obstetrics and Gynecology), new and reopened, Part I, and requests for re-examination Part II are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is August 1, 1959. No applications can be accepted after that date.

Candidates are requested to write to the office of the Secretary for a current Bulletin if they have not done so in order that they might be well informed as to the present requirements. Application fee ($35.00), photographs, and lists of hospital admissions must accompany all applications.—ROBERT L. FAULKNER, M.D., *Secretary, 2105 Adelbert Road, Cleveland 6, Ohio.*

PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

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Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I Know About It,
Wis. M. J. 54:717–719 (Dec.) 1954.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

Pneumoperitoneum Following Tonsillectomy

By N. A. McGREANE, M. D.
Darlington, Wisconsin

PNEUMOPERITONEUM following surgery about the head is not a common occurrence. Therefore the following case is presented.

Case 1—A white male, age eight years, was admitted to the hospital on July 13, 1957 for tonsillectomy and adenoidectomy. He had a history of recurrent tonsillitis accompanied by submaxillary gland enlargement.

Physical examination was normal except for persistent submaxillary adenopathy. The patient was taken to surgery at approximately 9:00 A. M. General anesthetic was induced with vinyl ether (vinethene) and open drop ether then administered until the desired stage of anesthesia was reached. Ether administration was continued through a nasal catheter connected to the ether suction machine. The ether mixed with air was thereby administered by pressure to the pharynx (pharangeal region). It was noted at the time of surgery that the tip of the nasal catheter was at the mid-pharangeal area. The tonsils were removed by dissection and snare. A small persistent bleeder in the left fossa was ligated. The adenoidal tissue was removed with an adenotome. Total operating time was about 20 minutes. When surgery was completed and the drawsheet removed from the patient, it was noted that the abdomen was markedly distended, respiration inhibited, and extremities cold. A stomach tube was passed with removal of a small amount of gas and about one ounce of clear fluid. A rectal tube was inserted, and neostigmine (prostigmin) administered. These measures were of no benefit to the patient. Flat plate was made of the abdomen which showed massive pneumoperitoneum (fig. 1). Paracentesis was performed midway between pubis and umbilicus with removal of approximately 1,500 cc. of gas as measured with a 20 cc. syringe. This reduced the distention markedly and also improved the patient's general condition.

Fig. 1—Roentgenogram of abdomen showing pneumoperitoneum.

All of the gas was not removed at this time since it was felt that too rapid removal might precipitate vascular collapse. On the following day 1,000 cc. of additional gas was removed by the same means. Gastric suction was continued for three days with administration of fluids parenterally. A combination of 400,000 units of penicillin G procaine in aqueous suspension and .5 gm. dihydrostreptomycin sulfate was given intramuscularly every 12 hours for three days. After the second paracentesis the patient felt well. The highest temperature was 100.4 F. on the second postoperative day. White blood cell count taken on the 13th, 15th and 18th of July did not exceed 13,600.

The patient was discharged on the fifth postoperative day feeling quite well and taking nourishment in adequate amounts. Bowel function was normal at that time.

On July 29th an x-ray of the upper gastrointestinal tract was reported normal.

Since the probable source of the gas is known in this case it would be classified as accidental rather than a true spontaneous

pneumoperitoneum. Rogers and Jones[1] reported a case of spontaneous pneumoperitoneum in a 15-year-old girl following tonsillectomy under open ether anesthesia. Schneewind[2] in a report on spontaneous pneumoperitoneum commented on a patient developing a pneumoperitoneum following the administration of oxygen through a nasal catheter inadvertently placed in the hypopharynx. Maddock, Bell and Tremaine[3] reported a patient with pneumoperitoneum due to spontaneous rupture of a dilated stomach which occurred during a minor operation under thiopental sodium (pentothal sodium) anesthesia. There also have been cases reported following gastroscopies without demonstrable stomach wall perforation.

In these, as well as the case reported, no pathology was demonstrated either by clinical means or surgical exploration, nor was the route by which the gas entered the peritoneal cavity shown. Absence of residual air in the mediastinum would seem to preclude the possibility of gas leaving the respiratory tract or upper gastrointestinal tract and reaching the abdominal cavity through the mediastinal space and diaphragm.

The gastrointestinal tract remains as the most likely route of the gas, although no positive proof of the mechanics of this is available. With the mouth held open and frequent suction in use, it would appear that gas delivered to the pharangeal area would have less resistance passing out through the mouth than in passing through the esophagus to the stomach. This passage to the stomach in considerable amount undoubtedly did occur in this reported case. It is probable that a minute break in the wall of the gastrointestinal tract occurs, allowing gas—but not solid or liquid—to enter the peritoneal cavity aided by the pumping action of the diaphragm. When the pressure in the peritoneal cavity equals or exceeds that in the gastrointestinal tract, the opening is sealed. Some authors have commented on the mechanics of swallowing as a factor in building up gas pressure in the gastrointestinal tract.

Under these conditions it would seem that treatment can safely be conservative with paracentesis, gastric suction, antibiotics, parental fluids, and close observation of the patient for evidence of peritoneal irritation as shown by fever, pain, elevated white blood cell count, and developing muscle guarding. If these should occur, surgical exploration would be indicated.

Summary

1. Possibility of pneumoperitoneum should be considered when abdominal distention appears after surgery or nasal O_2 administration.

2. Care in placing nasal catheters used for gas administration so the tip remains in the nasopharynx may reduce possibility of this complication.

128 East Ann Street.

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American College of Cardiology to Meet with AHA

This year for the first time the American Heart Association's annual Scientific Sessions, to be held in Philadelphia, October 23–25, will include a joint program with the American College of Cardiology. The College, holding its 8th Interim Meeting concurrently, will conduct "Fireside Conferences" on Friday evening, October 23, in which Heart Association members will participate. On Sunday afternoon, October 25, a panel on "Cardiac Resuscitation" will be presented jointly by the College and the Association's Council on Clinical Cardiology.

Present Day Concepts of Muscle Relaxants*

By HAROLD R. GRIFFITH, M. D.**
Montreal, Canada

SO QUICKLY DOES operating room practice change that it is difficult for many surgeons and anesthesiologists to remember after 15 years some of the problems of abdominal surgery before the introduction of curare and other muscle relaxants. None of us wants to go back to those "good old days" when we had to depend only on deep ether, deep chloroform, or spinal anesthesia for adequate exposure in difficult cases. While it is true that most of our patients survived, there were some who undoubtedly were poisoned by too deep anesthesia, and some operations done today routinely and almost nonchalantly were unsatisfactorily performed on account of muscle tension. In almost every operating room throughout the world some drug whose principal action is muscle relaxation is now in daily use. I shall attempt briefly to review the story as to why and how this revolution in anesthesiological practice has come about.

Curare was the first muscle relaxant to be used in combination with clinical anesthesia. It became accepted rapidly and with enthusiasm because it met a need. One cannot say that about every new drug which is presented to the medical profession—many drugs are simple variants of something presently in use which the manufacturer or some physician is trying to promote because of an apparent minor difference in action. The need, however, for good muscle relaxation in abdominal surgery was perfectly obvious, and surgeons and anesthetists had dreamed for many years of some magic wand which, without harm to the patient, could produce just this effect.

A new biologically standardized extract of curare called "intocostrin" was brought to my attention in 1940 by Dr. L. H. Wright of New York. He suggested that it might be used to provide muscle relaxation in patients under general anesthesia. Because of the fabulous reputation of curare as an arrow poison, I laughed at the idea of bringing such a substance into the operating room, and so did everyone else to whom Doctor Wright propounded his idea. However, I kept thinking about it, and after I had studied reports of how this preparation of curare was being used by Bennett in Nebraska for the softening of convulsions in psychiatric patients undergoing shock therapy, I concluded that it was worth a trial in anesthesia. So on January 23, 1942, my associate, Dr. Enid Johnson, and I administered the first dose of intocostrin to a patient undergoing appendectomy at the Queen Elizabeth Hospital of Montreal. This proved to be somewhat of a historic event. The effect of the curare was so demonstrable, so consistent, and so apparently harmless that after 25 cases we published our first report.[1] This led Dr. Stuart Cullen of Iowa[2] and soon others, to try the drug; and before long numerous reports were appearing in medical journals. Almost all the early reports were in moreorless enthusiastic confirmation of our original findings. So, because it filled a need, curare spread quickly into the operating rooms of many countries.

Another result was that pharmaceutical manufacturers and research pharmacologists began to look for other drugs which could be used as curare substitutes. This started a chain-like reaction which soon produced myanesin, then decamethonium and the ganglionic blockers, "C5" and "C6", and gallamine (flaxedil), and led indirectly to the whole field of "tranquilizers." The synthetic muscle relaxants, decamethonium and gallamine, and a methylated tubocurarine called "metubine" or "mecostrin" have come into fairly wide clinical use as substitutes for curare. These and certain other less widely used drugs like "mytolon," "prestonal" and "laudolyssin" may, in my opinion, be used in about the same fashion and with the same effectiveness as d-tubocurarine. The only muscle relaxant to be used in combination with anesthesia which is significantly differ-

* Presented at the one hundred seventeenth meeting of the State Medical Society, May 8, 1958, Milwaukee, Wisconsin.
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ent from curare is succinylcholine (which is known by various trade names—"anectine," "brevidil," "scoline," etc.). This drug when used intravenously is so short acting that the relaxation produced is usually of predictable and controllable duration. By altering the rate of flow of succinylcholine in a dilute solution by intravenous drip, one can "turn on" or "turn off" relaxation as is required during a surgical procedure. This is a major advance in muscle relaxant drugs, and in my personal practice I have almost completely abandoned curare in favor of succinylcholine. Apart from this development, I am no longer much interested in the comparative clinical study of all the relaxant drugs which come on the market. There are, it is true, slight differences between them in duration, in dosage, in solubility, and in price. But the attempt to find a drug which will relax skeletal muscles and still not affect respiration is, in my opinion, a futile search. It just does not make physiologic sense.

An elaborate study of "the effect of some curarizing drugs in unanesthetized man," has recently been made by Poulsen and Hougs,[3] in Copenhagen. They note certain differences in the effects of tubocurarine, decamethonium, gallamine, and succinylcholine, but there is no significant "respiration sparing" effect in any of them.

Speaking as a clinician of some experience, I believe that any anesthesiologist who uses muscle relaxants can forget the differences or the imagined advantages of one over the other, and remember that the danger to the patient is just about the same from all of them. That danger is primarily from respiratory depression with accompanying hypoxia and hypercarbia. If the anesthesiologist is alert and intelligent, these are the easiest complications to prevent or to counteract. The remedy which should be at our fingertips at all times is simply adequate pulmonary ventilation. Whether respiration is carried on spontaneously, or is manually assisted or controlled, or whether it is supported by an automatic ventilator makes no difference provided it is physiologically adequate in relation both to the provision of oxygen and elimination of carbon dioxide.

Some years ago Dr. Henry Beecher, of Boston, undertook an extensive "study of deaths associated with anesthesia and surgery" in a selected group of American teaching hospitals. The comprehensive report of this investigation appeared in *Annals of Surgery,* July, 1954,[4] and was later published as a monograph. One of the factors which Beecher tried to evaluate in relation to operating room mortality was the incidence of the use of curare. The figures tended to indicate that a patient to whom curare had been given was six times more likely to die in the operating room than was the patient who had had no curare. Beecher did not claim that curare could be proven to be the cause of any single death, but he did say that there must be some undisclosed "inherent toxicity" in curare. This suggestion was so alarming that many surgeons felt that the use of curare should be forbidden. Beecher's report was challenged by anesthesiologists, his inferences from the available statistics were questioned, and much controversy ensued.

After the first flurry of alarm, the use of curare and other muscle relaxants has continued in almost all operating rooms; and I think we can accept the fact now that this type of drug successfully meets such a need and that it has a firmly established place in modern surgical practice. In my opinion the results of Beecher's study have been beneficial in that it emphasized first of all the importance of anesthesia as a cause of death and secondly, the need for further study into the causes of deaths associated with anesthesia. It has stimulated a reappraisal of muscle relaxants.

I agree entirely with Beecher when in his summary he says muscle relaxants should "be employed only where there are clear advantages to be gained by their use, that they not be employed for trivial purposes, or as a corrective for generally inadequate anesthesia." I am sure I am right in saying that it is the opinion of most thoughtful and experienced anesthesiologists that the primary safety factors in clinical anesthesia are meticulous attention to every detail of administration and individualization in the management of patients. These are of much more importance than the choice of any particular anesthetic agent or muscle relaxant. In Great Britain a committee of the association of anesthetists has made a careful report[5] on 1,000 deaths occurring in the operating room in the years 1950–1955, and the authors conclude that 598 of these were anesthetic deaths. In the great majority of those cases there appeared to be some departure from accepted practice, indicating that the conduct of the anesthetic for a particular patient may

have a more important influence on the outcome than the use of one or another agent.

When in 1942 we first used curare, no one foresaw the tremendous development in this whole new class of drugs which came about in the next 15 years. It is interesting now to speculate what still lies ahead in further developments in this field. We know a great deal now about the nature of transmission at the myoneural junction, and we can talk with some exactitude about such things as "competitive inhibition," "depolarizing block," and "nondepolarizing block," but there is still much to be learned. There is evidence now that some agents may produce a mixed type of block, and that in some patients the effect of a given agent may be different from its effect in other patients.[6] So long as we have tubocurarine and succinylcholine available, I personally do not care whether or not any new relaxant agents are discovered, but there probably is a place in clinical anesthesia for an ultra short-acting nondepolarizing drug of the curare type whose action can be reversed chemically (as tubocurarine can be reversed with neostigmine).

A few years ago we thought we had such a drug with "prestonal," but that had other disadvantages and has not been widely adopted. There are recent reports[7] about unexpected complications arising following the administration of muscle relaxants to patients who have recently received certain antibiotics. A neuromuscular blocking effect has been demonstrated with large doses of neomycin, and probably also streptomycin and some others. Unusually severe apnea may be the result of a summation of the action of these presumably unrelated types of drugs. The current practice of spraying a relatively large amount of neomycin into the abdomen of a patient undergoing laparotomy, may be dangerous if a muscle relaxant is being used. At least, under these circumstances the possibility of quite prolonged apnea must be recognized and measures taken to maintain adequate ventilation. Absorption from the peritoneal cavity is almost as rapid as if a drug is given intravenously. I believe also that the mixing of different muscle relaxant drugs in the same patient during one operation is a bad practice. It is never really necessary and may lead to unpredictable results.

An anesthesiologist should rely mainly on one drug which he knows well, administer it in intelligent dosage, tailored to that particular patient's measure; and maintain proper respiratory ventilation constantly. Whenever these conditions are carefully followed, curare and other muscle relaxants have proved to be a blessing to patients as well as to surgeons.

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New Bibliography Available on "Fungus Infections"

The National Library of Medicine has just issued *Fungus Infections*, a bibliography on systemic and superficial fungus infections. This is another in its series of selective bibliographies on subjects of current interest. Others in the series are on space medicine, cancer chemotherapy, and staphylococcal infections. A complete list of such bibliographies is available. Single copies of the bibliographies can be obtained at no cost upon request to the: Acquisition Division, National Library of Medicine, 7th Street & Independence Ave., S.W., Washington 25, D. C.

Trauma During Delivery and the Consequences*

Trauma may result from normal spontaneous deliveries or from certain obstetrical interferences during labor and delivery.

Trauma and the resultant hemorrhage may be mild or so severe as to be lethal to the mother and at times to the infant as well.

These factors have been responsible for a sufficiently large maternal and fetal loss, as determined by our Maternal Mortality Study in Wisconsin, that major emphasis should be given them.

Every woman who is pregnant has inherent to this condition certain potentialities for sustaining trauma and hemorrhage.

Every physician who cares for the expectant mother should be constantly alert to the signs of impending crisis due to trauma and hemorrhage, be able to recognize such signs and, in addition, be ready to cope with such situations on short notice. This requires not only surgical facilities but *sufficient properly typed and crossmatched blood for replacement of loss.*

The mild trauma, such as moderate lacerations of the cervix, vaginal wall lacerations, and tears of the perineum or extension of episotomy wounds should be searched for and immediately repaired.

Severe trauma, such as extensive vaginal wall lacerations, deep cervical tears, third degree tears into the rectum and rupture of the uterus demand more extensive search and definite procedures. *Uterine and vaginal packs are no substitute for proper estimation of damage to the maternal soft parts and proper repair of vaginal or cervical laceration or extirpation of a ruptured uterus.*

Delivery from below by means of high application of the forceps, or extremely difficult forceps deliveries are to be discouraged. If the delivery cannot be effected with a degree of facility consistent with good obstetrical principles, then the procedure should be considered a "failed procedure" and Cesarean section should be substituted.

Manual dilitation of the cervix is a dangerous procedure and results in manual tearing and dangerous trauma. There is no place for this procedure in modern obstetrics.

Version and extraction is rarely, if ever, indicated. If performed at all, then the several requirements must be met.

1. Adequate pelvis
2. Complete dilitation of the cervix
3. Deep relaxing types of anesthesia. For example, ether or chloroform. *Spinal, Saddle block, Epidural block, N_2O_2 and O_2 are not sufficiently relaxing.*
4. Delivery and skill in the performance.

Stimulation of labor by oxytours can result in severe trauma and *should never be used* in the following situation:

1. The grand multiparous patient
2. In obstructive labor
3. In cases of abrupto placenta or placenta previa
4. In patients who have had previous Cesarean sections
5. Multiple pregnancy or overdistention of the uterus with hydramios
6. For convenience of patient or physician.

The intra-muscular use of alphahypophamine (Pitocin) is far more hazardous than the use of dilute solutions intravenously, and the rate of flow should be gauged to produce contraction of desired frequency and intensity. *The physician should be in attendance and at the bedside during the administration. This is not a function which can be properly assigned without direct and personal supervision.*

Previous Cesarean section and the allowance of the patient to labor: the physician's attendance should be mandatory here and surgery and blood should be immediately available. This applied as well to patients who have had myomectomies.

Adherence to the above principles will result in the saving of several lives in Wisconsin each year.

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* Summary of talk presented by T. A. Leonard, M.D., Madison, at Maternal Mortality Institutes of the State Medical Society and the Wisconsin State Board of Health at: Racine, January 15, 1959; Sheboygan, January 22, 1959; and Appleton, January, 29, 1959.

Macroglobulinemia

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IT IS THE PURPOSE of this presentation to discuss the present status of macroglobulinemia. Macroglobulinemia may occur as a separate entity. It is also associated with malignant conditions involving the reticuloendothelial system.

Waldenström, in 1944, described essential hyperglobulinemia.[1] This condition was most often seen in elderly males. The onset may be characterized by weakness, asthenia, lassitude, dyspnea, weight loss, occasional fever, and central nervous system degeneration. The condition may be associated with purpura, retinal hemorrhages, epistaxes, bleeding gums, and hemorrhages within the central nervous system.[2] The course may be chronic. Pernis, *et al.* reported two cases in which the patients have been doing well for two years.[3] The course is relatively rapid in some instances. The lymph nodes may be enlarged along with hepatosplenomegaly.

The hemorrhagic tendency is not known to be associated with any demonstrable abnormal coagulation factors.[2] The macroglobulins can pass into the spinal fluid and through the capillaries into the tissue spaces. The precipitation of these abnormal proteins may be a factor in hemorrhage.[4] In one series of 17 cases reported, there were five cases of hemorrhagic retinitis.[5]

The purpura of macroglobulinemia must be differentiated from the disease called purpura hyperglobulinemia. This condition has also been described by Waldenström. It is characterized by purpura in the presence of apparent normalcy of the blood coagulation factors and an increase in gamma globulins. It has a flat "virus type" gamma globulin peak, while macroglobulinemia has a sharp gamma globulin peak as seen on paper electrophoresis. However, a case of macroglobulinemia showed a hyperglobulinemia-type of electrophoretic pattern.[2] Thus, there is no absolute diagnostic electrophoretic pattern. Hyperglobulinemia is not associated with macromolecules.[2] There are probably transitions between these two forms. This confusing picture is seen in other conditions as will be noted.

In macroglobulinemia, Bence–Jones protein may be present in the urine. The anemia is usually normochronic, moderately severe, and persistent. It may be hemolytic in nature. Pancytopenia may be present. There may be eosinophilia, lymphocytosis, or monocytosis. Thrombocytopenia may be severe. The sedimentation rate is elevated. There is hyperproteinemia with hyperglobulinemia associated with hypo-albuminemia. The formol-gel test may be positive.[6]

Mast cells may be present in bone marrow and lymph nodes. Heparin from these cells may be a factor in the hemorrhagic diathesis.[7] Plasma cells may vary in degree in the bone marrow. The condition can be confused with plasma cell myeloma which was true in one of our patients to be discussed later. The cells may be mature or atypical, but without the diffuse or nodular involvement seen in myeloma. This will differentiate these two conditions. The lymphocytic proliferation is often indistinguishable from lymphocytic leukemia with lymphoid cells comprising up to 70% to 90% of the bone marrow.[4] One can speculate that at least some of these may be true cases of lymphatic leukemia that are associated with macroglobulinemia.

These lymphocytoid cells may be indistinguishable from true lymphocytes. Some show cytoplasmic loss from protoplasmic shedding with naked nuclei seen, but these are also present in other conditions.[6] The lymphocytes in the peripheral blood parallels those in the bone marrow.[5]

Four cases of macroglobulinemia were originally diagnosed as lymphosarcoma by lymph node biopsy.[6] One can again speculate that these were true cases of lymphosarcoma associated with macroglobulinemia. This will be discussed later.

The electrophoretic mobility of the proteins may show a narrow and tall globulin pattern as seen in myeloma. This was true of our patient. At times the peaks may not be prominent in myeloma because the myeloma component may be present in low concentration.[7]

Myeloma proteins occasionally have the mobility of alpha globulins[8] or there may be four distinct peaks.[9] Also, the peaks may not be prominent in macroglobulinemia.[2] Therefore, the electrophoretic pattern is not always diagnostic in either condition. These abnormal proteins usually migrate similarly to gamma globulin. Occasionally they may migrate like "M" globulins and least often similar to beta globulin.

The condition should be suspected when plasma cells and lymphocytes are present in excessive numbers in the bone marrow along with evidence of an abnormal protein in the serum as determined by rouleaux-formation, elevated sedimentation rate, and a positive Sia test. Filter paper electrophoresis of the serum may reveal a component indistinguishable from myeloma proteins. This combination makes the diagnosis of macroglobulinemia almost certain.[6]

Case 1—Our patient was a 58-year-old male who developed chills, fever, anorexia, and malaise. The fever continued intermittently and did not respond to therapy. The physical examination was negative except for some walnut-sized nodes in the left inguinal area. The electrophoretic pattern was suggestive of multiple myeloma. The albumin was reduced to 41% (normal 59%); the gamma globulin was 29% (normal 13%); the alpha 1 and 2 as well as the beta fraction were about normal. The total proteins were 7.4%. The C-reactive protein was 2 plus. The white blood cell count was 18,000. The differential was normal. The formol-gel was milky at first. Gel formation occurred in three hours.

The bone marrow showed many plasma cells, but there were no skeletal changes. There was no evidence of Hodgkin's disease. A lymph node biopsy from the left inguinal area showed a small focus that was suggestive of Hodgkin's disease, but the findings were not conclusive.

X-rays of the kidneys, pelvis, spine, colon, and stomach were not remarkable.

The patient developed a severe anemia and ran a rapid downhill course and died about five months after his original symptoms.

The post mortem examination showed Hodgkin's granuloma. There were also a large number of plasma cells present throughout the marrow.

We believe this was probably a case of macroglobulinemia associated with Hodgkin's disease on the basis of the electrophoretic pattern, the abnormal reaction to the formol-gel test, and the presence of many plasma cells in the bone marrow. The serum should have been examined for macroglobulins, but this was not considered at the time. Two other cases of Hodgkin's disease having a myeloma-type of electrophoretic pattern will be referred to later.

Macroglobulinemia must be distinguished from myeloma, lymphosarcoma, and lymphocytic leukemia for reasons already noted. The histologic appearance of the lymphoid tissue may change from a lymphocytic to a plasma cell reaction during the course of a disease.[10, 11, 12]

Plasmacytoid cells may rarely appear in the blood and bone marrow.[13] The lymphoid cells are said to be a curious transition to plasma cells.[2]

It has also been stated that macroglobulinemia can simulate or evolve into multiple myeloma.[2] However, macroglobulinemia may be a condition that is added to myeloma in some cases.

Euglobulin may be present in macroglobulinemia.[2] This protein is tested by adding a drop of protein to distilled water. A turbidity develops in the presence of euglobulin which is soluble in sodium chloride. This is called the Sia test. This is said to be a good screening test, but false positives may occur especially in multiple myeloma.[6]

Cryoglobulins become gelatinous at lower temperatures and redissolve on warming.[14] Their molecular weight may go up to 1,000,000.[15] In periarteritis nodosa there may be present proteins that are precipitated at lower temperatures, but do not redissolve on warming. In this way, they can be differentiated from cryoglobulins. These are also noted in cirrhosis and in subacute bacterial endocarditis.[16] Cryoglobulinemia may be present in macroglobulinemia. This protein was first described by Wintrobe.[17] This patient had Raynaud's phenomenon with retinal hemorrhages. Large quantities may be found in cases of chronic lymphocytic leukemia, kala-azar, bronchiectasis, disseminated lupus erythematosus, rheumatic fever, arthritis, subacute bacterial endocarditis, and hepatic disease.[17, 20]

There is no agreement on the etiology of idiopathic macroglobulinemia. Waldenström suggested a possible virus. It has also been considered to be a primary disturbance of the reticulo-endothelial system,[14] resulting in abnormal function rather than abnormal cell structure.[6] Abnormal proteins are then synthesized.[2]

The macroglobulins in macroglobulinemia are antigenically abnormal,[21] and they are

antigenically deficient when compared with the normal macroglobulins.[22] The morphologic basis of primary macroglobulinemia remains poorly defined. The histologic diagnosis associated with the published cases illustrates the confusion that exists. These include atypical lymphatic hyperplasia,[12] lymphadenopathies,[23] lymphosarcoma,[24] diffuse myelomatosis,[25] a variant of multiple myeloma,[26] and atypical leukemia.[2]

In a series of 25 cases of macroglobulinemia, 12 were associated with lymphocytic hyperplasia, 7 cases showed lymphocytic and plasma cell hyperplasia, 4 showed transitional-cell types. In 2 cases there were no abnormal cells noted.[6]

It was thought to be a possible epiphenomenon in the course of lymphosarcoma.[6] Macroglobulinemia has also been considered to be an independent or an induced mutation in a malignant lymphoma.[6] There is some doubt that the condition is pathognomonic of one syndrome since the case reports are so diverse and there is no substantial agreement regarding the histopathology.[27]

If macroglobulinemia is an essential feature of the disease, as Waldenström suggests, it would be reasonable to expect that the abnormal macroglobulinemia should be present from the onset of the symptoms. One case is reported in which macroglobulinemia was not present for more than two years. This patient had been sick for two years and had an easily palpable spleen. Some form of reticulosis was thought to be present. There was no disturbance of the albumin globulin ratio and an ultracentrifugal analysis was normal. Some months later there was a reversal of the albumin globulin ratio without an increase in total circulating protein. An electrophoretic analysis indicated it was due to a component resembling gamma globulin. At this time there was a significant macroglobulinemia. The water test was positive. A splenic biopsy showed pleomorphic reticulosis. The post mortem findings were those of an atypical Hodgkin's disease in the spleen.[27]

It has been surmized that the anemia might be due to "stifling" of the bone marrow by the turgid macromolecules and this contributed to the rapid downhill course.[27] Five cases were reported that had an increase in cells whose cytoplasm was rich in pyronine positive staining material.[27] This is true in the majority of cases associated with hypergammaglobulinemia whether or not excess of macroglobulins are present.

Azar[28] reported 13 cases of malignant lymphoma and lymphatic leukemia, including 1 case of Hodgkin's disease, which were associated with myeloma type of serum proteins similar to those seen in macroglobulinemia. Ten of the cases showed a marked plasmacytosis. There were pyroninophilic reticulum and lymphoid cells present. The findings indicated a cellular derivation of the abnormal protein component present and a potential metabolic disturbance common to some lymphatic neoplasms and plasmacytomas. In spite of these differences, macroglobulinemia does occur in the absence of any other specific disease. It must be considered to be a single independent disease entity probably associated with lymphoreticular hyperplasia.[14]

Summary

In summary, macroglobulinemia may be associated with a disease related to the reticulo-endothelial system. These may be classified on a histologic basis such as lymphosarcoma, lymphatic leukemia, or Hodgkin's disease. Various other descriptive terms have also been used to denote the reticulo-endothelial involvement. These are mentioned in this paper. In one case of atypical Hodgkin's disease, the macroglobulinemia appeared more than two years after symptoms developed.

There are instances of macroglobulinemia that cannot be definitely placed in a special category or classification. These cases are termed primary macroglobulinemia.

Many of the cases with macroglobulins show pyroninophilic reticulum and lymphoid cells which would indicate a potential metabolic disturbance.

Macroglobulinemia should be suspected when plasma cells and lymphocytes are present in excessive numbers in the bone marrow, along with evidence of an abnormal protein in the serum as determined by rouleaux-formation, elevated sedimentation rate, and a positive Sia test. Filter paper electrophoresis presents a myeloma pattern. A case with several of these findings is presented. The final diagnosis is the actual demonstration of the macroglobulins.

St. Luke's Memorial Hospital.

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Midwifery, Microbes and Modern Obstetrics*

By JOHN PARKS, M. D.**
Washington, D. C.

IT IS WITH a deep sense of appreciation and a true feeling of homecoming that I return to this lecture hall to speak in the memory of a great teacher and good friend, Doctor John Warton Harris. I am very grateful to Doctor Peckham, Dean Bowers, and the Alumni Committee for the honor and privilege of sharing this Wisconsin Medical Alumni Day with you.

Doctor Harris came to Wisconsin in 1928 from Johns Hopkins University where he had been a capable student and loyal associate of Doctor J. Whitridge Williams. It was four years later during the course of my junior year in the Medical School that I first became well acquainted with Doctor Harris. From there on, a deep friendship developed.

Doctor Harris always held the attention of his students for he was a master of his subject. He was a true teacher and a splendid speaker. Among his residents, his aphorisms were legend; his judgments were respected, and his friendship was unwavering. We all remember with a warm feeling favorite expressions of his such as "pay your money and take your choice" and "the quintessence of asininity and stupidity." During all the years that I knew him, Doctor Harris never failed to meet his classes promptly at the appointed hour and he never missed a home football game. No adopted son of Wisconsin ever tried to live closer to the mottos of our University, "Numen Lumen" and "On Wisconsin," than did Doctor Harris.

I am not only deeply pleased to present this memorial lecture before our fellow alumni and students but also in the presence of Doctor John Warton Harris, Jr., the elder son of Doctor and Mrs. Harris. The younger Doctor Harris, Jack as we know him, is here today. He will complete his residency training in obstetrics and gynecology with us at The George Washington University Hospital this month.

In reviewing the life work of Doctor Harris, it is apparent that he lived through and contributed to one of the most significant periods in the history of medicine. Although Doctor Harris is best remembered at Wisconsin as a stimulating, warm and capable teacher, his contributions as a clinical bacteriologist at an important turning time in medical progress form the theme of my talk today.

Working on the wards and in the laboratories of The Johns Hopkins Hospital, Doctor Harris developed a clever device for taking vaginal cultures without labial contamination.[1] With scientific precision he demonstrated that the uterus in pregnancy is usually sterile up to the onset of labor; that ascending infections increase with each additional hour of labor after the sixth; that intact membranes are not a thoroughly protective barrier against infection; and that the absence of vaginal examination does not preclude bacterial contamination. This information was of real significance in the pre-antibiotic days because it gave a basis for the selection of different types of operative delivery. His studies of the avenues of bacterial invasion; his identification of the invaders, and his fundamental clinical rules regarding the prevention of puerperal infection form an important chapter of his earlier professional life.[2, 3, 4, 5]

Doctor Harris knew the history of midwifery and early obstetric practices. He was introduced shortly after graduation from The Johns Hopkins School of Medicine in 1916 to an epidemic of influenza which contributed, along with the practices of the time, to the highest maternal mortality rate of this century. Doctor Harris' professional life span of 39 years (1916–1955) practically overlaps this chart showing maternal mortality in the United States 1915–1954. (Chart 1). What great pride he took in tell- in the United States had become 10 times safer than it was in his student days! He had been a forward moving party to this progress. He had seen man's partial control

* The annual John Warton Harris Memorial Lecture, delivered at the University of Wisconsin, June 5, 1958.

** From the Department of Obstetrics and Gynecology, The George Washington University.

CHART 1
MATERNAL MORTALITY, 1915–1954, UNITED STATES BIRTH REGISTRATION AREA

(Reprinted from Statistical Series No. 42, U. S. Department of Health, Education and Welfare, Social Security Administration, Children's Bureau, Chart 11, Page 10.)

of the helpful and harmful microscopic members of the earth's living things. He lived not only to recognize the value, but to warn against the abuse and overuse of antibiotics. Some of his most descriptive figures of speech were in condemnation of the use of prophylactic penicillin as a substitute for antiseptic principles and aseptic techniques. Time has proved him right. Antibiotic and drug resistent micro-organisms again threaten the safety of patients who enter hospitals for childbirth or surgery.

Midwifery

Let us take a closer look at microbiology as it has influenced the history of midwifery and modern obstetrics. Obstetrics is the most fundamental of all medical sciences. It deals with the very beginning of life. As the science of human reproduction obstetrics is very ing his students that childbirth for mothers young.[6] Van Leeuwenhoek's (1632–1723) description of the spermatozoon and Karl Ernst von Baer's (1792–1876) discovery of the ovum occurred less than 300 years ago. Even after these basic discoveries, another 100 years passed before it was realized that reproduction resulted from the union of these two human cells.[7] Although the science of obstetrics is of recent development, the art of midwifery is as old as man.

Early in the second century, Soranus described the prerequisites for midwives as follows: "We call a person the best midwife if she is trained in all branches of therapy (for some cases must be treated by diet, others by surgery, while still others must be cured by drugs). . . . She will be unperturbed, unafraid in danger, able to state clearly the reasons for her measures; she will bring assurance to her patients, and be sympathetic. She must be robust on account of her duties, but not necessarily young as some people maintain, for sometimes young persons are weak whereas on the contrary older persons may be robust. She will be well disciplined and always sober, since it is uncertain when she may be summoned to those in danger. She will have a quiet disposition, for she will have to share many secrets of life. She must also keep her hands soft . . . . Long and slim fingers and short nails are necessary to touch a deep lying inflammation without causing too much pain."[8]

These standards, including possibly the long slim fingers with the short nails, still have merit. Speaking of fingernails, I have been told, with no authenticity whatsoever and with no personal experience, that midwives and some of our earlier obstetricians nurtured at least one long fingernail with which to rupture the membranes.

Except among the early Colonists, midwifery never achieved in America the popularity which it has had throughout the years in Great Britain and Europe. America of colonial days was an admixture of British, French, Scandinavian, and Spanish peoples transported and transplanted to a land inhabited by primitive Indians. In Thoms' "Chapters of American Obstetrics", Benjamin Rush, famous physician and a signer of the Declaration of Independence, is quoted as saying about Indian women, "Nature is their only midwife. Their labors are short, accompanied by little pain. Each woman is delivered in a private cabin without so much as one of her own sex to attend her. After washing herself in cold water, she returns in a few days to her usual employment, so that she knows nothing of those accidents which proceed from the carelessness or ill management

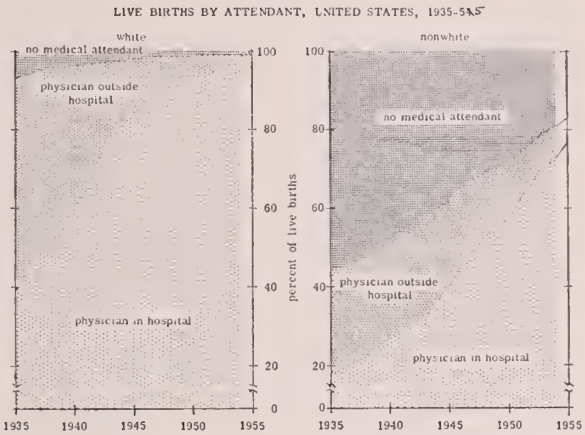
of midwives. . . ."[9] Stoical self delivery is described similarly in Pearl Buck's book, "The Good Earth," the only difference being that the Chinese woman used hot water.

Harvey, the great observer and first British author to write an original work on midwifery (1651), was succeeded about a century later by the not too scrupulous, secretive Chamberlens. After the use of forceps became common knowledge, midwifery was taken up by male practitioners known as "men-midwives," "mid-men," physician men-midwives, surgeon men midwives, "extraordinary men-midwives." The invasion of men into a profession long considered the possession of women created conflict and brought forth invectives of a descriptive nature. For example, the British midwife, Mrs. Elizabeth Nihell, classified the famous Doctor Smellie as a "great-horse-god-mother of a he-midwife."[10]

While there is documented evidence that women served well as midwives in the homes of the early settlers of our country, there must have been reasons why a concomitant system of professional midwifery failed to form a part of our medical progress in obstetrics. Perhaps the conflict between midwives and physicians occurring in England at a time when the Constitution of the United States was taking form encouraged physicians on this side of the Atlantic to take over the art of midwifery. Dr. William Shippen had the courage to start a course in midwifery in Philadelphia in 1762. A feeling of professional as well as political independence prevailed. Thoms suggests that lack of lying-in hospitals early in America's history may have had an influence on midwifery.[9] Certainly when hospitals were established for maternity services they were controlled largely by physicians. Only in isolated instances such as the renowned Frontier Nursing Service, conceived and ably directed in the hills of Kentucky by Mrs. Mary Breckinridge, the Sister Theophane Center in Santa Fe, and the Maternity Center in New York City, have nurse-midwives served with distinction during the last quarter century in the United States.

With a rising population and a predicted increase in birth rate, Dr. Nicholson J. Eastman has strongly advocated university hospital training of nurse-midwives to meet the demands of the future.[11] If nurse-midwives are to become an important part of our professional future they will have to receive training in obstetrics comparable to that given medical students. The drunken, scheming Sara Gamps of Dickens' days[12] have disappeared in England and granny midwives are rapidly losing their practices in America. The following chart serves to illustrate the remarkable change in nonmedical-attended and physician-attended births in and out of hospitals which has occurred in our country in two decades, 1935–1955. (Chart 2). In

CHART 2
LIVE BIRTHS BY ATTENDANT, UNITED STATES, 1935–1955



(Reprinted from Statistical Series No. 42, U. S. Department of Health, Education and Welfare, Social Security Administration, Children's Bureau, Chart 1, Page 1.)

1955, 98% of white patients and 78% of the nonwhite mothers were delivered by physicians in hospitals.

Microbes

Medicine progresses with courageous men and turbulent times. Charles White of Manchester was such a man, living in an era of rapid political and professional change. Excerpts from his excellent, "Treatise on the Management of Pregnancy and Lying-In Women," published in 1773, have merit today. "True puerperal fever" he attributed to a "putrid atmosphere or long confinement of the patient in a horizontal position." To facilitate lochial drainage he advised elevation of the patient's head and shoulders. For those of us who thought we discovered a few years ago the advantages of early ambulation, this quote comes from Charles White, "The sooner she gets out of bed after her delivery the better, even on the same day if possible."[10]

With the introduction of forceps and with greater attention being directed toward mid-

wifery by scholarly men, a growing concern began to take form for the great number of young mothers who died of dreaded chills and high fevers so soon after childbirth. Like many a good diagnosis in medicine a strong impression precedes laboratory confirmation. Such was the case with puerperal fever.

For example, Harvey said in 1651, "For it often befalls a woman (especially the more tender sort) that the afterpurgings being corrupted and grown noisome within do call in Feavers and other grievous symptoms." He likened the placental site to a "large inward ulcer" and advocated adequate uterine drainage by dilatation of the cervix.[10]

It is natural that American students of medicine should like to give credit to Oliver Wendell Holmes for first stimulating our thoughts about this disease by his scholarly essay in 1843 on "The Contagiousness of Puerperal Fever." However his thoughts were strongly influenced by a publication of an earlier date. In 1795, Alexander Gordon had presented a "Treatise on the Epidemic Puerperal Fever of Aberdeen." The epidemic was associated with an outbreak of erysipelas in that city. Gordon observed by autopsy that erysipelas of the womb involved the placental site just as it did external wounds. Unfortunately Gordon lived only a short while after he became interested in puerperal fever and left but one classic paper on that disease.[13]

Opposition to his theories prompted Holmes to present his second thesis in 1855 under the stronger title of "Puerperal Fever as a Private Pestilence." Holmes visualized puerperal infection as a contact disease transmitted by the physician or midwife. He advocated that a physician who had come in contact with erysipelas or who had done a post mortem examination on a patient with puerperal fever should not attend a woman in labor for some weeks thereafter. A physician who had a series of patients with puerperal fever should consider himself the vehicle of contagion. His second essay contained these challenging words: "Whatever indulgence may be granted to those who have heretofore been the agent and cause of so much misery? The time has come when the existence of private pestilence in the sphere of a single physician should be looked upon not as a misfortune but as a crime and in the knowledge of such occurrence, the duties of the practitioner to his profession should give way to his paramount obligations to society."[13]

At about the same time that Holmes was advocating antiseptic methods to prevent puerperal fever in Boston, Semmelweiss was noticing on the wards of the Vienna Lying-in Hospital that the mortality from childbirth was much higher where women were delivered by students than where the mothers were attended by the midwives. He began to study the habits of medical students, a procedure which always carries with it some degree of personal hazard. Semmelweis deducted correctly that students were carrying infective material directly from the post mortem rooms to the delivery beds of the new mothers. Semmelweiss died a tragic death trying to teach students and staff the importance of cleansing the hands with chlorinated lime water before attending a woman in labor.

These excellent deductions by White, Gordon, Holmes, and Semmelweiss were finally confirmed in 1879 when Pasteur demonstrated streptococci in the uterus as well as in other organs of a woman who had died from puerperal fever. In 1887, Doderlein demonstrated that staphylococci also cause patients to die of puerperal sepsis.[14]

With evidence available that bacteria cause puerperal infection attention could then be directed with scientific accuracy to the development of effective germicides. The ancient Egyptians had extensive knowledge of antiseptics and preservatives which they used not for the protection of the living but for preservation of the dead. Happiness after death depended for them upon a well-kept mummy. The word antiseptic originally meant against putrefaction. Early observations of effective antiseptics were gained from their use on vegetable and animal matters to prevent fermentation and putrefaction. While empirical practices with antiseptic agents go back to man's earliest recorded history, the scientific use of germicides is less than a century old. Some of the early germicides were effective deodorants used to dispel the odor of disease.[15] Through careful observations and a forceful publication in 1867, Lister popularized carbolic acid as an effective antiseptic in surgery.[16] Fortunately in the light of later events, phenol proved to be such a stable and effective germicide that it became the coefficient by which other disinfectants were measured.

Following Pasteur and Lister and before the discovery and use of the sulfonamide drugs, treatment of puerperal infection was seldom satisfactory. Recovery varied with

the virulence of the infecting organism and with the resistance of the individual patient. Accordingly great emphasis was placed on prevention of infection by rigorous methods of antisepsis. For example, Bacon recommended (in 1884) thorough disinfection of the external genitalia and surrounding skin followed by washing of the vagina with lysol or criodin. After a sterile speculum was inserted, the vagina was swabbed with liquid soap, followed by strong criodin solution and finally alcohol was used—all without the benefit of analgesia or anesthesia. Bacon said, "Do not expect complete preparation of a patient (for vaginal examination) in less than 15 minutes."[14]

Undoubtedly many physicians did not go into such antiseptic detail before doing a vaginal examination and it is easy to understand why the patient would be willing to dispense with such preparation. One of the real problems in the use of antiseptic techniques has consisted of finding solutions which are death dealing to surface bacteria without causing irritation and injury to the epithelium.

In the Nineties treatment of puerperal infection consisted of uterine irrigations, thorough curettage, and drainage of the uterus with iodoformized or carbolated gauze. Some physicians preferred wicking to packing of the uterus. Eliot recommended that if peritonitis developed, as it often did, the patient should be turned over to the surgeons for removal of the tubes, ovaries, and the pus from the peritoneal cavity. Eliot said, "Peritonitis very many times leaves a woman in that state of individualism to which death is a wished-for-relief and from which she will not be rescued by electricity, by massage, by douches, by tampons, or by any amount of internal or external medical treatment. Cases pass beyond the influence of these measures and should be handed over to the surgeon."[17] Not all of Eliot's contemporaries agreed with him on the surgical approach to this problem, but the majority recommended a strongly antiseptic uterine douche with an unobstructed tube for return flow.

At the turn of the century hospitals were so infected that home delivery was seven times safer for survival than hospital confinement. During the first quarter of the twentieth century serious and heated debates centered about asepsis and semi-empirical surgical procedures. For such conditions as placenta previa where hemorrhage and infection often joined forces against the life of the mother, Jewett presented a comparative summary of practices in 1909 which showed the maternal mortality to be 10.9% with obstetric delivery and 11.5% when abdominal cesarean section was used.[18]

Although the technical skills of many of our earlier obstetricians were great, surgical progress was slow. Efforts were made to isolate the infected from the noninfected mothers. Green soap, iodine, alcohol, and various colored mercurial compounds were used freely. In some areas where asepsis was rigidly controlled and strong antiseptics were used with discretion, abdominal surgery and prophylactic forceps began to show therapeutic advantages. Surgical cure of serious maternal infections began to become more of a reality. For example, Doctor Harris reported in 1928 the recovery of a patient whose uterus was removed in the puerperium because it contained intramural miliary abscesses and another patient whose ovarian veins were ligated to prevent additional septic emboli from a postabortal infection.[19] This latter procedure with added ligation of the inferior vena cava is an operation currently advocated by Collins in the treatment of pelvic thrombophlebitis.[20]

Although individuals and certain clinics reported periods of relative freedom from infection for their patients, the maternal mortality from puerperal septicemia in the birth registration area of the United States showed no appreciable change until 1936. Repeated small transfusions helped build up patient resistance against infection and concentrated streptococcus antitoxic serum[21] seemed for a short while to have a therapeutic place, but these measures were accompanied by unfavorable reactions and incomplete cures. Just as forceps, introduced in a surreptitious and underhanded way, changed the course of operative obstetrics, the presentation of prontosil under secret formula to the practicing physician in 1935 marked the birth of modern obstetrics.[15]

Modern Obstetrics

Colebrook's excellent re-evaluation of the sources of infection in puerperal sepsis set the stage for the use of chemotherapeutic agents.[22]

Prontosil was only the first of a series of sulfonamide drugs each of which was rapidly

evaluated by rather liberal clinical usage in all fields of medicine. I shall always remember prontosil as the drug which gave me the greatest therapeutic thrill of my resident days on Doctor Harris' service. A patient with postabortal sepsis and peritonitis had received full treatment with supplementary fluids and repeated small blood transfusions. She was hovering on the physiopathologic balance scales only a few degrees above death. A sample supply of prontosil became available to us. I had the dubious privilege of giving this new drug late in 1935 to our patient. Although she turned a bit blue from methemoglobinemia, which we at first interpreted as a step closer to death, her post-prontosil recovery was truly a medical miracle.

The sulfonamide drugs provided a new and effective weapon with which to inhibit bacterial growth and invasion. For the first time we had specific systemic rather than local means of combatting puerperal infections. Maternal deaths from puerperal septicemia declined from 24 per 10,000 live births in 1935 to 7.3 in 1945.[23] Death represents a sure measure of mixed therapeutics. It reflects broad trends. The wide margin of life between health and death is more difficult to evaluate. However, it is a clinical fact that the sulfonamides contributed more to gynecologic health than had any prior medication. The sulfonamides were accompanied too by a few hazards one of which was a surprising increase in ectopic tubal pregnancy.

Man's control of his microbiotic environment was well under way, but better weapons were still to come. Alexander Fleming reported in 1929 his observations of the antibacterial action of penicillium.[24] In a brilliant cooperative study at Oxford, Chain and Florey together with their colleagues presented penicillin as a chemotherapeutic agent in 1940.[25] In the center of another world conflict dedicated scientists were brought together against man's two greatest enemies, disease and the destructions of war. Florey's refinement of penicillin was followed by another commendable cooperative venture when America's productive freedom and abilities were enlisted to produce the drug. By the war's end penicillin had been subjected to extensive clinical trial. It became available for general use.

Many physicians going on the principle that a drug should be used while it is popular, over-prescribed penicillin. Its prophylactic properties were difficult to evaluate. What it prevented remained unknown. Except for an occasional patient with a severe allergic reaction to penicillin this first antibiotic of wide clinical value has been found to have little toxicity.

The term antibiotic was introduced by Waksman in 1942 to define chemical substances of microbial origin which possess antimicrobial activity. Others were to follow. Streptomycin to combat gram-negative organisms was introduced in 1944. Chlortetracycline (aureomycin) came into clinical usage in 1948; chloramphenicol (chloromycetin) in 1952; and the tetracycline group became available in 1953.[26]

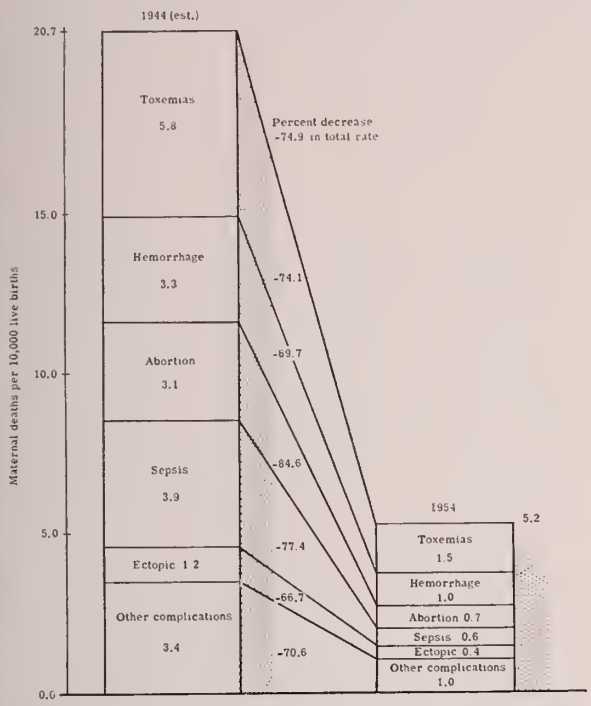
During the developmental period of the sulfonamides and antibiotics, progress was being made too in surface antiseptics. For the most part green soap gave way to more effective detergents. Iodine and tincturated antiseptics were being replaced by equally efficient nonirritating, more nearly isotonic bacteriocidal solutions.

By 1955 maternal death from septicemia was 1 per 10,000 live births. Thus, in 25 years death from puerperal sepsis had become 25 times less likely in 1955 than in 1930.[23] The decade of greatest progress in controlling sepsis began in 1945. The following chart (chart 3) illustrates the tremendous influence antibiotics have had on puerperal sepsis. Advances in obstetric practice are easily demonstrated. The chemotherapeutic agents and antibiotics have brought similar security to the practice of all medicine and surgery.

Concurrent with the control of infection came more reasonable and less dramatic obstetric procedures. For example, office vaginal examinations are used more frequently today. Using antiseptic measures vaginal examination in the latter weeks of pregnancy adds immensely to the physician's information about his patient's progress and permits better planning for the conduct of labor.

A so-called "sterile" vaginal examination is actually only half sterile. The instruments and gloves should be sterile, but it is impossible to sterilize the patient's epithelial or mucosal surfaces with an antiseptic. Nonirritating, effective antiseptics make vaginal examination more comfortable and much safer for the wide awake patient than ever before in obstetric history. I shall not debate the relative merits of vaginal and rectal examinations. Ask your patients which they

CHART 3
MATERNAL MORTALITY
Main Causes by Sixth Revision of the International Lists, United States, 1944 and 1954



(Reprinted from Statistical Series No. 42, U. S. Department of Health, Education and Welfare, Social Security Administration, Children's Bureau, Chart 12, Page 11.)

prefer and ask yourself which provides the greatest information. Properly done neither should introduce new bacteria, but both disturb the cervico-vaginal flora.

Some time ago we discontinued the use of green soap as a vaginal lubricant and antiseptic at the time of delivery. Aqueous benzalkonium or pyridium chloride and a water soluble jelly are much better and far less irritating than green soap to the genitalia of the mother and to the skin of the newborn.

Rarely does the obstetrician of today perform a version or extraction, a destructive operation on the fetus, a cesarean section after hours of neglected labor, or a highly traumatic forceps delivery. These were fairly common procedures 20 years ago. Trauma and blood loss prepare the patient for infection. The usual operative methods currently carried out in hospitals are based upon sound obstetrical and surgical principles, backed up by indicated laboratory information and supported by careful medical knowledge of the individual patient.

Because of the greater ease with which it can be repaired, because the patient has less postpartal discomfort, and as a result of better anesthesia, the median episiotomy or perineotomy has become the most frequently used operative procedure in obstetric practice. If there is any reason to suspect laceration of the birth canal or retention of placental parts, immediate exploration of the vagina and uterus is indicated before the patient leaves the delivery room. Midforceps delivery is undergoing the same scrutiny today that was applied to high forceps during the first quarter of this century. For the most part midforceps operations can be avoided by careful vaginal examination during labor, by x-ray pelvimetry, by the indicated use of alphahypophamine (pitocin) to stimulate contractions, and by caudal anesthesia. Vaginal examination determines the character of the presenting part; the presence of any soft tissue obstruction, and the degree of muscle tone. If the pelvis is adequate, if the vertex is engaged and if the muscles are tense, caudal anesthesia may be used to advantage. In a recent survey of 15,084 mothers delivered of 15,220 newborns at The George Washington University Hospital, only 212 (or 1.4%) were delivered with midforceps. In the same group of patients 676 (or 4.4%) were delivered by cesarean section. Through control of infection, better anesthesia, and ready availability of blood for transfusion, cesarean section today is a much safer procedure both for the mother and her newborn than is a traumatic vaginal delivery.[27]

The vast majority of women in our country are now delivered in hospitals by physicians who have a deep sense of responsibility to the mother, to her infant, and to the family. By providing clean, well equipped delivery and operating rooms for their maternity patients, hospitals have added immensely to the safety of the mothers and their newborns.

As a physician who feels rather strongly that the obstetricians should have an interest as well as a shared responsibility for the baby's welfare long after the cord is cut, I would be remiss not to mention progress in the control of infections of the newborn brought about by the use of multiple, clean, small nurseries rather than the large nursery units which form a prominent part of our obstetric past.[28]

During the past 12 years, obstetricians, nurses, and hospital administrators have tended to make maternity facilities more homelike. Greater freedom in the hospital between mother, newborn, and family has

been received by the public with enthusiasm, but a few prospective parents have asked for more. They want family access to the delivery room. Some husbands feel that they should be with their wives throughout the entire birth process. Without debating the psychologic advantages and disadvantages for all concerned in such a proposal, one point seems quite clear. Until such time as we can control all forms of contact and droplet infections in delivery rooms, only well prepared and indicated personnel should be admitted to that area of the maternity department.

Along with the availability of chemotherapeutic drugs and the so called "broad spectrum" antibiotics a certain false sense of safety has developed. Physicians, nurses, and medical students have again become less thorough in their use of the time tested principles of asepsis and antisepsis. An old and battle tried enemy in the form of the coagulase positive Staphylococcus aureus has remained with us. There is nothing new about the way this yellow staphylococcus grows, contaminates, invades, and kills. However, as an antibiotic resistant organism, the Staphylococcus aureus is rapidly becoming a real threat to world health. In surface infections the staphylococcus can be controlled without any great danger by antiseptic preparations, but as an invader of damaged tissues deep in the hidden recesses of the body cavity this is a death dealing organism. Our only current means of combatting this potential killer is by intensive and prompt treatment with novobiocin or chloramphenicol.

The teachings and practices of Doctor Harris were deeply influenced by his fundamental knowledge and experimental research in microbiology. He knew microbes as well as men and women. He warned us of a possible bacterial break through the antibiotic barrier. The time is at hand to redirect our attention to the prevention of infection. Cure may not be possible. Unless all personnel coming in contact with patients in our hospitals can be taught the principles of asepsis and antisepsis as advocated by Doctor Harris and other teachers of the pre-antibiotic era, the advantages of hospitalization and surgical methods of delivery may again be lost by default to a microscopic invader, the Staphylococcus aureus 42B/52/81,[29] currently public enemy number one of the delivery and operating rooms.

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Mortality Trends from Acute Infectious Diseases Excluding Influenza and Pneumonia—Wisconsin, 1958

By JOSEF PREIZLER, M. D., M. P. H.*
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OF THE 37,000 deaths in Wisconsin in 1958, 130 were caused by acute infectious diseases. In this discussion, deaths due to pneumonia and influenza are omitted because they need special interpretation. The mortality trends of the others are considered as they appear on death certificates filed with the Vital Statistics division of the Wisconsin State Board of Health. Some of the information was obtained also from follow-up correspondence with the attending physicians.

TABLE 1—CAUSES OF DEATHS DUE TO INFECTIOUS DISEASES
(Excluding Influenza and Pneumonia)
Wisconsin—1958

Acute Exanthemata	
Scarlet Fever	1
German Measles (Rubella)	3
Chicken Pox (Varicella)	5
Measles (Rubeola)	14
Bacterial Diseases: Meningitides	
Meningococcal Meningitis	15
Pneumococcal Meningitis	6
H. Influenza Meningitis	5
Streptococcal Meningitis	3
Staphylococcal Meningitis	1
Pseudomonas Meningitis	1
Cryptococcal Meningitis	1
"Purulent" Meningitis	10
Bacterial Diseases: Other	
Bacillary Dysentery	4
Tetanus	3
Whooping Cough	1
Staphylococcal Septicemia	6
Streptococcal Septicemia	2
Proteus Septicemia	1
Septicemia (etiology unknown)	3
Viral Diseases	
"Viral Infections"	8
Viral Encephalitis	11
Infectious Hepatitis	12
Poliomyelitis	2
Miscellaneous Conditions	---
Total	128

Varicella

The "common" childhood viral diseases are usually considered "harmless." Nevertheless, chicken pox deaths occurred in 3 infants of 2, 3, and 8 months of age who died with an accompanying pneumonia. Two other deaths were in children 3 and 6 years of age and attributable to encephalitis.

Rubella

Of the three rubella deaths, a year-old child died from pneumonia following rubella, a 12-year-old girl died from acute encephalitis following rubella, and the third death reported was in a 4-year-old child who developed pneumonia during her rubella infection. The diagnosis of rubella by virus studies is difficult. The children suffering from this disease were first seen by physicians when the late complications occurred and the diagnosis had to be made chiefly from the history given by the mothers or on epidemiologic considerations.

Rubeola

AGE DISTRIBUTION OF PATIENTS DYING FROM MEASLES

Age	Number of Cases
Under 1 year (1 mo., 24 days)	1
1 to 2 years	3
2 to 3 years	3
3 to 4 years	3
5 to 6 years	1
Adults (24, 36, 39 years)	3
Total	14

All the children under 3 years of age and the adults died from bronchopneumonia (10 cases). Of the remaining 4 deaths, 3 had symptoms of encephalitis and the fourth case was in a microcephalic child who died from status epilepticus.

Bacterial Meningitis

A. Meningococcal

AGE DISTRIBUTION OF PATIENTS DYING FROM MENINGOCOCCAL MENINGITIS

Age	Number of Cases
Under 1 year	5
1 through 4 years	5
6 through 10 years	2
Adults (48, 56, 79 years)	3
Total	15

Five of the 10 children above died from the Waterhouse-Friderichsen syndrome.

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B. Pneumococcic

Four deaths from pneumococcic meningitis occurred in persons older than 70 years—all 4 died in January and February 1958. One may speculate about the role of the "Asian flu" in these cases.

C. "Purulent"

The "purulent" meningitis group is a mixed one and includes nonspecific bacterial meningitis. Five patients were young children. Of these, 3 were infants 1 year old, one a child 3 years old, and one a child of 7. The other 5 were adults, 3 of whom were over 70, one over 65, and one almost 50 years of age.

Viral Diseases

Six of the 12 hepatitis deaths occurred in patients 70 years old and older. One child aged 5 years died from this disease.

The group reported as "viral infections" represents a vague classification. Some of these cases may belong to deaths caused by the influenza epidemic occurring in 1958.

The diagnosis of "viral encephalitis" does not indicate the etiology. Four of the 11 deaths were in patients younger than 2 years. At this age children react often with central nervous system symptoms (convulsions, somnolence) in many febrile illnesses and so the diagnoses without autopsy may be questioned. The seasonal and geographic distribution of the remaining 7 cases gives no clues with which even to speculate about the specific viral etiology.

General Age Distribution of Acute Infectious Disease Deaths

TABLE 2—AGE DISTRIBUTION OF REPORTED DEATHS FROM ACUTE INFECTIOUS DISEASES
(Excluding Influenza and Pneumonia)
Wisconsin—1958

Less than 1 year	7
1– 4 years	34
5– 9 years	9
10–19 years	10
20–29 years	2
30–49 years	17
50–64 years	12
65 and over	37
Total	128

Although table 2 gives the acute infectious disease deaths numerically by unequal age groups, it should be noted that almost 40% of them occurred under 10 years of age and an equal percentage occurred in persons over 50 years of age. This rate for each extreme of life is twice the percentage distribution of these age groups in the general population since the 0–9 year group constitutes 22%, and the 50 and over age group constitutes 20%. Another factor of importance in these age groups is the relatively high susceptibility of the younger group to exanthematous disease and decreased resistance of the older group to bacterial infection.

One should not be deceived by the low number of deaths in the under one year age group. It must be remembered that the group has some passive immunity for almost half the first year of life. This group comprises about 2½% of the general population yet contributes 5½% of all the deaths. Even more serious consideration must be given to the 65 and over age group in which 37 deaths occurred. This represents 29% of all the deaths from acute infectious disease while it comprises only 9% of the general population.

Diseases due to acute exanthems, meningococcal meningitis, "viral infections," and the encephalitis group caused most of the deaths in the younger age group. Meningitis caused by a variety of bacteria, infectious hepatitis, and septicemia due to different micro-organisms were the common causes of deaths in the older age groups.

Recommendations

People are still dying from the so-called common infectious diseases despite the fact that very effective preventive procedures are available for such of them as: gamma globulin for measles and infectious hepatitis; tetanus and whooping cough immunizations; Salk vaccine against poliomyelitis; influenza vaccine; penicillin prophylaxis for streptococcic infections and "sulpha" medication for persons exposed to meningococcal meningitis. Early diagnosis with bacteriologic verification of the etiologic agent can give, in many cases, a clue for effective antibiotic medication. In view of the high case-fatality in the extremes of life, strong supportive treatment must be seriously considered for cases in these age groups.

A great need for the proper study and evaluation of the significance of acute infectious diseases still exists. Good reporting and good clinical and epidemiologic evaluation of these conditions will materially help to meet such need.

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COMMENTS ON TREATMENT

Have We Overlooked Urea?

By HARRY BECKMAN, M. D.
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UNDER THE PROVOCATIVE title, "Urea, the Forgotten Diuretic," Papp and Smith, of the London Chest Hospital,[1] have offered a new assessment of the diuretic properties of this drug, from which they conclude that when integrated in action with mercurial diuretics it has a special place in the therapy of chronic heart failure with edema. Study was made of 17 patients with obstinate and prolonged right ventricular failure. Fourteen had chronic rheumatic valvular heart disease, and some of these had cardiac hepatic cirrhosis with ascites; 6 underwent mitral valvotomy. Two of the other patients had coronary heart disease and the third had hypertensive heart disease. Urea was administered in doses of 15 gm., dissolved in 57 ml. of water or grape juice 3 times daily. Treatment was maintained for 2½ weeks to 7 years. In about half the patients a negative fluid balance was changed to positive on urea alone. In cases in which it remained negative, fluid retention became less. Urea produced such effects even after mercurial diuretics had been useless. In several patients mercurial diuretics were greatly augmented in their effect when urea was given concurrently.

At worst urea administration was felt to be never harmful, but it may have to be discontinued on account of the patient's distaste or because of nausea and vomiting. At best it may be the means of maintaining in nonstrenuous occupation for several years a patient in whom this result is unattainable by other medications singly or in combination. Between such extremes are patients in chronic congestive failure who may receive many months of benefit, at first by prolongation of quiet activity free from edema, and later by mitigation or abolition of distressing edema and effusions until the last days of the illness. It may certainly be said that urea has one great advantage, shared with few of the other diuretics, of continuing to exert its effect as long as its administration is continued, though of course not irrespective of the advancing pathology. In the presence of reduced renal function it may contribute to the picture of nitrogen retention.

The dermatologic uses of urea have recently been emphasized by Kligman, of the University of Pennsylvania,[2] who states that, owing to its lack of toxicity, concentrations of the drug of 40% or more may be used topically. At these strengths the antibacterial effects are said to be similar to those of the antibiotics, with the further advantage that all the common organisms are susceptible and the possibility of resistant strains need not be seriously considered. Urea is also considered to have a strong proteolytic action and to be mildly keratolytic. It is an effective deodorizer, chiefly because it suppresses bacterial overgrowth.

Kligman says that compresses and soaks of 40% urea may be used advantageously for inflammatory skin lesions presenting elements of exudation, suppuration and crusting, especially if there is evidence of secondary infection. It is the "dirty" lesion, regardless of origin, for which urea is suited. Conditions for which he advises its use, provided the specifications of a "complicated" dermatitis are met, include contact dermatitis pre-eminently, burns, impetiginized eruptions, nummular eczema, various kinds of hand and foot dermatitis, and any eczematous process in which suppression of bacteria and debridement appear desirable. If the lesion is of the kind that does not heal spontaneously when it has been "cleaned up" by soaking and compresses, the underlying process must be treated by other measures after the superimposed infection has been

removed. For the primary pyodermas, impetigo, ecthyma and the like, antibiotic ointments are clearly superior, in Kligman's opinion.

Urea is said to be of value for initial local treatment of suppurating wounds, necrotic malignancies, foul ulcers with a purulent slough and similar lesions. The crystals are liberally sprinkled into the lesion and covered with a wet compress to effect solution, or a 40% compress may be applied directly. With treatment maintained for 20 to 30 minutes and repeated several times daily, striking deodorization may be achieved and variable reduction in the accumulated discharge and slough. Streptokinase–streptodornase combinations or trypsin may be more debrideing in a shorter period, but Kligman says that often the final result is not much more striking. Since the latter agents are not antibacterial, their deodorizing abilities are far less notable.

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Catastrophic Situations in the Delivery Room*

MATERNAL RESUSCITATION

In spite of being in the vigorous decades of life and going through a physiologic event that is not usually attended by complications, the obstetrical patient at times presents an unequaled potential for disaster.

Prevention

Prevention of the need for maternal resuscitation is paramount and takes its origin in the early treatment of minor degrees of respiratory and circulatory deviations: respiratory depression, hypoxia, respiratory obstruction, hypotension, fluid imbalance, and blood loss.

Shock

Shock due to blood loss in the obstetrical patient represents an extreme degree of loss, because it marks the break in the compensation of a very active and strong mechanism . . . TREATMENT MUST BE HEROIC.

Meet the need by correcting the hypotension and shock rapidly to prevent irreversibility.

This means administering blood via large gauge needles, two at a time, under pressure if necessary, for as many units as 500 cc. as is required to return and maintain the blood pressure.

* * *

Help!

Most times maternal resuscitation is not a "one-man band". The help of another doctor should be sought promptly.

Take Inventory

Take inventory of your obstetrical department to determine whether the tools for maternal resuscitation are readily available: intravenous solutions, blood administration sets, pressure sets, large gauge needles (13g—15g—18g), oxygen, and endotracheal equipment.

Check with your laboratory to learn how quickly crossmatched blood can be available under all conditions. *Be sure that low titer universal donor blood is always on hand* to tide over until crossmatching is done.

* Summary of talk presented by William Kreul, M.D., Racine, at Maternal Mortality Institutes of the State Medical Society and the Wisconsin State Board of Health, January 15, 1959, Racine, January 22, 1959, Sheboygan, and January 29, 1959, Appleton.

The "Home" of the State Medical Society of Wisconsin

By W. D. STOVALL, M. D.
Madison, Wisconsin

On the occasion of an Indiana meeting at which the organization was considering a proposal to construct its own association headquarters building, Doctor Stovall was called upon to convey the philosophy of the building as it applied to the State Medical Society of Wisconsin of which Doctor Stovall has been an active participant in its building program.

His remarks were printed in The Journal of the Indiana State Medical Association, August, 1958, issue, and are reprinted here with permission.

THERE ARE a great many reasons why it is important for a State Medical Society to have an office building of their own. We in Madison, like other medical societies in the country, have our County Societies and our State Society. For many years the County Societies were loosely organized. The State Medical Society was loosely organized. We had a meeting once a year and, in between, the Council met once or twice a year and business was transacted in a very lackadaisical fashion. But we are living in modern times now, and we as doctors have grown up to be not only doctors but statesmen. We have subjects that we have to discuss, we have to understand, we have to have opinions upon, which influence us not only in our practices and in the practice of medicine, but they also influence all of the people of our states. For that reason, if for no other reason, it is very important that a State Society have a place where the committees can meet and where they can discuss their problems by themselves, unto themselves, in a surrounding that will be inspirational for wise deliberation.

You know medicine is a part of the fabric of our social order; it is not something separate and distinct from every other profession, every other trade, every other industry. And it is the way we behave ourselves and the way we live and how we act on important questions that portrays to the public the relation of medical practice and medical science to all phases of industry and skills and to all types of philosophical reasoning. We cannot any longer just be doctors. We do not any longer practice from our medicine cases. We practice in offices and we practice in the hospital, and we make our offices attractive because we want to and must dignify the profession in which we are practicing. We must be recognized as professional in our offices, in our hospitals, and in our meeting place where our business is transacted. We must also be statesmen and, for that reason, we want to have the proper place of meeting.

Now, a proper place to meet is important for another reason, because it shows the place of medicine in the social order. Medicine is a part of the fabric of society; it is a part of the warp and woof of the whole organization of society. It is just as much a figure in the social order as the figure that is woven in the rug; it cannot be blacked out without destroying the rug; it is part of the weave. Because it is part of the weave, we have to be a part of the social order.

The proper relation to the social order portrays the doctor in the framework of modern science and it integrates him with all kinds of sciences—social science, physical science and all kinds of philosophies. You are not separated from all of the people and the issues that surround us and all the issues that are causing so much dispute today. It not only does that but it shows the doctor in relation to his patients and what he has done for the care of the sick and what he is doing for the care of the sick and it shows the doctor in relation to the health and public welfare of the people of his community, his State, and his Nation. These are all-important problems to the people and it is an important matter of public policy that the people know that the doctors are discussing these issues.

I was quite interested a few months ago, I met a friend of mine who is an industrialist in the city of Madison—he doesn't have a large industry but he is an important person. He had been out at the State Medical Society in Madison at a meeting where we were discussing a very important public issue; it surrounded the relation of medicine to medical education and general public welfare. He happened to be out on another piece of business but, because he was there, he had an opportunity to sit in the area where he could hear the discussions. A few days later I saw that man and he said to me, "Doctor Stovall, I was inspired the other day at the debate that I heard in your Society on those issues that are so important to medicine and so important to the public and, more than that, I was thrilled to be in the environment in which you were discussing those issues. I thought it was conducive to straight thinking. I thought it was conducive to moderate action. I thought it was conducive to accurate and acute debate, in an atmosphere of friendship and deliberation."

I believe you cannot pay any higher compliment to an organization than to get that kind of a statement from a person who was not a doctor and he had never had such an opportunity before. So, as soon as we begin to think about our functions in that capacity, I think we begin to think immediately: Where are we going to carry on these deliberations?

As I told you, Wisconsin was loosely organized for some time. Then they began to meet to bring the Association tightly together, to have it well organized from the counties to the state, with adequate executive staff or administrative staff, with activity on the part of our Council and many other committees, because we had to keep in touch with all of these issues. And so, when we did that, we were meeting more frequently and we were meeting in an office building. There were no rugs on the floor, there were no pictures on the walls, there were typewriters and adding machines and office desks and bookkeepers and such things—just the bare necessities for operating a business industry, but there was nothing to inspire thoughtful consideration and deliberation.

We began to feel that we needed a home, we needed to be alone, we needed to be by ourselves. We needed to talk about medical issues there because what we were talking about were not only of concern to ourselves but of concern to everybody because we are part of the fabric of society—whether we like it or whether we don't like it, that's what we are. So, as we thought about that, then we began to campaign for a building of our own and I am very happy to tell you that it was while I was president the first one of those buildings was bought.

The first building was bought over on the northeast side of Madison, right on the shore of beautiful Lake Mendota. It was a large apartment house and we constructed it into an office building and the dedication of the building alone at the time was an inspiration to every member of our House of Delegates and all of the Councilors and all of the Medical Profession because they realized that, "Now I belong to an organization that owns property and that has a home."

We lived in that building for five years. Our committees increased, the number of subjects that we had to discuss was enlarged, and so we had to have a new building and we began to look around for where it should be.

We went to the opposite side of the city, on the shores of Lake Monona, and there we bought a piece of property upon which there were no buildings and we began to plan for a building for ourselves. Now, all of this was brought about—the picture which you saw this morning, this was all brought about not by those of us who live now. We practice in the atmosphere of what has happened before us. There is no such thing as a dead past. The dead live with us in what we do. It is not so much what we do today as what we think that prepares us for tomorrow.

For instance, the advancement of science has imposed upon the doctors a kind of practice and a skill that doctors who have preceded us did not have to have and did not know about. In order to keep abreast of that thing, we have to carry on many more meetings than we did before. And as these sciences spread out like that, the influence of the application of that science touches more and more the lives of people who are well and the doctor's sphere of influence enlarges and his problems get more deeper. We live in that kind of a society and we have that kind of a society because we have the heritage of those who have gone before us and they have made or contributed to these sciences.

You know the first thing that happens when you begin to get progress, and particularly medical progress, is that you have knowledge. After that knowledge is accumulated, then somebody gets a concept about how it might be applied for the benefit of those who are ill as well as the benefit of those who are well, and sometimes the people who get that concept are not doctors and the doctors wonder why they are invading our territory. But when we examine that concept and we find that the concept is good, and we do it in our own establishments, in our own home, in an environment that is conducive and inspirational for the tremendous job we have ahead of us.

After we get the concept then we begin to work out the technique by which this can be done and the techniques again mean that we have to develop a large group of people who surround us as doctors to get this job done, paramedical personnel. We have to purchase more equipment and we have industries that build up under the business that we make for them. We have contacts with those people and then we begin the application of all these sciences.

Let's just take an illustration. It is a very simple one, it is one that you all recognize, it is used by almost everyone who speaks, but it is applicable to what I am saying to you now—bacteriology. Bacteriology was in the process of formation for two

centuries alone before it was focused upon the fact that these microorganisms are the cause of disease, and, as soon as that was found out, there began to grow up great industries, great concepts out of great industries.

For instance, take aseptic surgery. They began to contrive a technique immediately as to how it would prevent all sepsis. Every surgeon wanted to delay operation just as long as possible because he knew if he operated on a patient he was exposing him to an infection which was probably worse than the one he already had. But Lister came to the front and he was using dressings and spraying carbolic acid in his operating room. But another great thing happened. A German all of a sudden discovered how to make an autoclave and get steam pressure and sterilize those dressings and he was just as important in this development of aseptic surgery as all the rest of them. Well, anyway, the steam autoclave came in and now we have a way of sterilizing these dressings. And so we went through the whole history of these things and in our country the rubber glove was developed.

The rubber glove was developed out of a thing that was quite compelling. A doctor in Johns Hopkins University had a nurse who was a very skilled person—refined, cultivated—and she had to scrub her hands so many times a day and with so much bichloride of mercury that she developed an eczema and he was going to lose her and he couldn't afford to lose his nurse. So he sent to the Goodyear Rubber Company and told his problem and he said "I want you to make a glove so thin it will not interfere with touch," and they made it and she put on gloves. And she worked for him three more years and then he took her out of service himself—he married her!

Well, now, this just shows you how our profession is touching on many of these things. It shows you how important we are growing.

In our building it is a great pride to me every time I walk in the place. You saw the pictures this morning. I brought some along to show you but I will not repeat them because you have seen them. But as I drive up to that place—we have a building that is on about three acres of land and it has an expansive parking place right out in front. The entryway is inviting, with aluminum doors and aluminum trim windows around the front of the entryway and into the lobby. And when I get into the lobby, I find a place that is colorful, delightful to live in. And in hot weather, in the summertime, it *is* air-conditioned. In this day and time when we have comfortable, why, in the name of sense, sweat all day in hot offices when you can be comfortable? That is what science is for—it is for the promotion of human welfare and to make life more comfortable and, if that isn't what science is for, then it is for absolutely nothing. I see people building nice big new buildings now and never putting air-conditioning in them. We are supporting research very largely and we should expect results and those results should be for the promotion of human welfare. Every time you do that sort of thing you bring the medical profession closer and closer in contact with the public and that creates social and economic problems that you must discuss.

There is not a weekend that goes by hardly in Madison that there isn't a large committee meeting in that building. You saw the Council Chambers. Every member of that Council feels more important, more business-like, more deliberative, when they walk in and sit down around that beautiful table with a bank of windows on that side of the building looking out on Lake Monona, and you get a view of the city of Madison across the lake. You cannot help but be more inclined to consider deliberatively your problems under such circumstances as that—at least I can not, and I believe you share that thought with me.

There is a lounge in there too. Auxiliary meets there. The Dane County Medical Society meets there. The large Committee on State Affairs of the State Medical Society meets there and that Committee on State Affairs is bringing in a lot of sub-committees and they are constantly informing themselves on the programs within the State administrative or Government administrative departments that touch upon medicine.

When you really come to understand it and when you stop to think about it, the very basis of all welfare is health. The very basis of it is health. If there is no health, you cannot promote good welfare. So when they go in there, they debate these problems, and not in a destructive way or in a hypocritical way, but they go there to find out what these people are doing and those people are invited into the meeting with them and they stay there and hear the debates, they hear what the objections of the doctors are and what probably can or cannot be done and in what way can be done and why they do not like it and, having the technical training that the administrators do not have, their reasons more often are correct than wrong—the doctors.

So we have many other committees. We meet with our Medical School and our University Hospital. We have the same debates that you have. We have the same difficulties that you have. The problems are great but medicine owes an obligation to medical education in the United States, and you owe an obligation to medical education in Indiana and we owe it in Wisconsin, and I think we are meeting it. We invite the Dean and whomever he likes to bring along with him, with a group or a committee which is organized particularly to look into the problems and advise with the Dean concerning these policies and what they should be. They have differences of opinion, of course, because they have different functions and different interests and you must understand that but, if you are deliberating in a place where you can appreciate that, "This is my home and this is my dwelling and here is where I, in a dignified manner, approach the problems of State as well as the problems of medicine," it is, to me, quite an important and thrilling thing.

I am not here to tell you what you should do—that isn't my business—but I am telling you what our building has done for the State Medical Society of Wisconsin, and I think your Council who visited there last year will tell you that this thing happened.

You know we have another obligation as long as we are a part of the social order. We have an obligation to give the public a concept of disease, its method of treatment, its prevention and its control. We are not chiropractors. Medicine has grown out of a social necessity. If a sick man had as good an opportunity and got along as well and his welfare was maintained as well as a well man, if a sick man got along as well as a well man, you wouldn't need doctors. So that this business of medicine has been with humankind from the very beginning of history. We just go at it differently because of the progress of science and our relation to the progress of science, and we need to give the public that kind of understanding for the public relation that it has, the effect that it has, and because we owe it as an obligation to our social order.

There was a man by the name of Smithson who lived in England. When he died he left his whole fortune to the United States Government. He was a young fellow. The Smithsonian Institute is the result, and in his will he said he wanted this given to the United States Government for the development of an institution that would disseminate knowledge to the people.

George Washington said in his Farewell Address that you must give prominence to the support of those institutions for the creation and distribution of knowledge for, in so much as the form of Goverment influences and puts into practice the opinions, it is important that they have the knowledge. In so much as Government puts into practice the rules and regulations that we must live by and practice by, it is terrifically important that we take part in our government.

So I am here to say to you, I think you would enjoy having a home of your own as much as we have in Wisconsin. I think it has given us a great deal of prestige to the Delegates throughout the whole State. We entertain distinguished guests there. You go up into the lounge and have a committee meeting or, when you have a distinguished guest, you bring him into the lounge and you have cocktails before dinner and then you go downstairs and go into the dining room and have your dinner looking out upon the waters of Monona and the city beyond. To me it is an inspiration.

I wish you the greatest success in your undertaking, I can't tell you how much good it has done for Wisconsin, and I am quite sure that when you have launched upon this project you will find that it assists you in doing many things that are possibly not being done now or that you are not doing so well. It has been a delight to be with you and I wish you great success.

"Medicine—a Lifelong Study" Is Theme of Big Chicago World Conference

Patterns of success and patterns of failure in the great cooperative movement to improve the health care of people everywhere will be exchanged and compared when medical educators from 50 different countries gather in Chicago for the Second World Conference on Medical Education, August 29 to September 4.

"This seven-day meeting, jointly sponsored by the great world bodies of medicine, will provide a common ground for the free exchange of scientific information and experiences between countries," said Dr. Louis H. Bauer, New York, secretary-general of the World Medical Association.

The conference is being held under the auspices of the World Medical Association, which was founded 12 years ago, one of its 7 objectives being "to assist all people of the world to attain the highest possible level of health." The association is now composed of 55 national medical associations representing about 700,000 physicians.

Collaborating with the World Medical Association in sponsoring the Chicago conference are the World Health Organization, the Council for International Organization of Medical Sciences, and the International Association of Universities.

President Eisenhower, who has been keenly interested in the financial problems of medical schools ever since his days at Columbia University where he helped organize the National Fund for Medical Education, is patron of the conference. He has been invited to address the opening plenary session on Monday, Aug. 31.

Doctor Bauer said that the Chicago meeting will mark the second time that the governments and the professions, working together, "have grasped the significance of health problems on an international scale for the benefit of all mankind." The First World Conference on Medical Education was held in London in 1953.

"This second conference," Doctor Bauer said, "will give medical educators an opportunity to examine the progress that has been made during the five-year interval in extending medical education—the real basis of all medical care—and raising its standards."

Care of the Pregnant Woman Over Forty Years of Age*

Usually a patient past forty has had several children, and fancies herself quite an authority on the subject. Her feeling of confidence and instinctive know-how seems to be accepted even by her physician, for she certainly calls all the turns, and dominates the scene generally. She is very apt to ignore all prenatal care, either for a socio-economic reason, or pride in her ability of professional motherhood.

The risk of maternity has constantly decreased during the past 30 years; however, the risk varies greatly with age. In a national survey conducted by the Health Information Foundation, for the years 1953–55 the fewest deaths occurred in age group 20–24—suffering a mortality of 3.2 per 10,000 live births. For all ages under thirty, a rate of about 4.3 was reported. Beyond age 30 the rate rises sharply until at age 45 and over we have 86.7 deaths per 10,000 live births.

The discrepancy in risk between younger and older women was once much less than it is today. In a comparable survey for the years 1921–23 the maternal mortality at age 45 and over was only about three and one-half times greater than the 20–24 age group, but by 1953–55 the comparable ratio was nearly 30 times greater.

This discrepancy is not due to any increase in mortality at either age group, but because effective improvement has generally been greatest at the younger ages and least at the older.

Birth order, too, is related to the safety of childbearing, even to some extent independent of the influence of age of the mother.

A large portion of the maternal deaths occurring in the older group of parturient women arise or are associated primarily with delivery. There is no doubt, however, that many of these catastrophic incidents have their origin during an unobserved portion of the gestation. Statistically, it appears that approximately ⅓ of the deaths occur during labor or the immediate puerperium. Another ⅓ are the result of toxemia and associated metabolic disturbances. Another ⅓ results from morbid conditions classified as complications of pregnancy which include those resulting from abortion, ectopic pregnancy, and conditions which we consider more or less accidental to pregnancy.

A recent survey in England and Wales, which generally confirms the results of earlier studies in this country and elsewhere, has shown that second births are safer than the first, and third even safer than second. With the fourth birth maternal mortality begins to rise again. Until, as the eighth birth approaches, the hazard has greatly exceeded that of a first birth. The management of a grand multip (a woman who has given birth to eight viable children) exceeds in risk any problem that may confront an obstetrician.

* Summary of talk presented by George S. Kilkenny, M.D., Milwaukee, at Maternal Mortality Institutes of the State Medical Society and the Wisconsin State Board of Health at: Racine, January 15, 1959; Sheboygan, January 22, 1959; and Appleton, January 29, 1959.

Oral Dental Examination in Physical Evaluation

Inclusion of an oral dental examination in the physical evaluation given patients on hospital admission is proving valuable for early diagnosis of cancer, according to the Veterans Administration.

Since the technique was adopted generally by VA hospitals about two and a half years ago, the hospitals have reported some 700 cases of malignancies of the mouth, tongue, and throat that might otherwise have been unidentified until too late for successful treatment.

The oral examinations by dentists also are proving to be a contributing factor in improvement of over-all diagnosis and treatment planning for patients in VA hospitals, especially for older patients.

The President's Page . . .

Establishment of Immunization Programs

In spite of the epoch making advances in the diagnosis, treatment and prevention of disease over the past twenty years, we as yet have relatively few specific methods of preventing disease to offer the public. The people of today are much more enlightened than ever, and one would feel that it therefore would be axiomatic for the public to take full advantage of what specifics we do possess in the medical management of disease.

The Report on Immunization Practices in Wisconsin, recently released by the Division on School Health and the Division on Maternal and Child Welfare of the State Medical Society, would indicate that such is not currently being done. What is more distressing is the indication in the report that the level of immunization against those diseases that can either be prevented or ameliorated is not being maintained at a point consistent with accepted safety and public health standards.

The reasons affecting utilization procedures by the public are many. Among them are:

1. Lack of epidemics, causing the public to believe that certain diseases are no longer prevalent.
2. Apathy, or ignorance on the part of the parents.
3. The economic factor.
4. Lack of emphasis on this phase of medical practice by the medical profession itself.

It is a basic responsibility of the practicing physician, the report states, to aggressively urge diptheria, pertussis, tetanus, smallpox and poliomyelitis immunization for his patients, especially during the first year of life. It is the basic responsibility of the medical society in each county to be specifically responsible for the scientific excellence and the quality of the medical care provided the people within its area. It naturally follows that it has a basic duty to assure the availability of immunizations at a reasonable cost for all of the citizens within its geographical area.

Each county medical society should establish such immunization programs as best suit the particular community needs. While the ideal method would seem to provide these immunizations within the privacy of a doctor's office, public or school clinics have their place in many communities.

The physicians' role in this vital area of medical practice in Wisconsin is the key to public response to immunization procedures. County medical societies are therefore urged to, as the report states, "Take the initiative and to cooperate in community planning, in order to bring about public understanding and acceptance of the needs for immunization."

William B. Weldenhammer M.D.

The Power of a Postage Stamp

The State Medical Society proposed a traffic safety stamp which may be a real help in fighting highway accidents. In a proposal to the Postmaster General of the United States the Council of the Society recommends the issuance of a special commemorative stamp on the theme of traffic safety, each year's stamp to receive its first day of issue from the capital cities of every state in the Union.

It's about time someone took the lead!

Traffic accidents each year kill more than 37,000 persons and injure another 1,400,000. The result is not only tragic suffering and loss of life but costs exceeding five billion dollars in wage loss, property damage and medical services.

There are Christmas Seals for tuberculosis. There are Easter Seals for crippled children. There is a postage stamp for polio. It's time that the same technique is utilized to bring the public's attention to one of the greatest single killers and cripplers of all.

There are postage stamps on people, places and things. There is a postage stamp urging the preservation of the last few hundred whooping cranes. If the nation can lick the shortage of whooping cranes with a stamp, can there be any doubt as to the desirability of using the mails to preserve some 37,000 human lives each year?

Already the idea has gained the support of the Wisconsin Senate, major insurance companies, safety councils and auto associations. It is an idea that deserves your support, too. Write your Congressman.

The Century Plan

Speaking of the growth of the professionally-sponsored voluntary health insurance plans in America, the *Saturday Evening Post* of June 21, 1958, said:

"Sparked especially by the pioneering efforts of Wisconsin Physicians Service these groups are beginning to offer a service-type comprehensive policy with no restrictive fee schedule, no limitations on family income and free choice of physician."

This was a fine tribute to the WPS–Blue Shield Special Service no-fee-schedule program, of which the physicians of Wisconsin can be proud. It was also a challenge of some substantial magnitude.

The Special Service or "no-fee-schedule" contract of which the SEP spoke so glowingly has proven itself, to date, to be an effective mechanism for providing health care protection without many of the "third party" impositions often associated with scheduled programs.

It demonstrates the type of leadership which the State Medical Society's Blue Shield program has made its major theme.

It is a leadership which the Society again assumes, hopefully, with The Century Plan for persons age 65 or over.

For several years the Society has been researching the problems of the aged. When the American Medical Association issued the challenge for immediate action on coverage for senior citizens, WPS–Blue Shield was in a position to move forward.

The Century Plan is regarded, as it should be, a first step toward meeting the needs of the elderly. With experience, the Commission on Medical Care Plans believes important answers can be found for previous unknowns.

Invitation to Disaster

The protection of the public against paralytic polio is dangerously incomplete. Despite the fact that 64,500,000 persons of all age groups have had a full series of inoculations, 97,600,000 have had none at all. Of the young people under 20 years of age, better than 13,000,000 are still unvaccinated. Even more appalling is the fact that one third of the children under five have not had a single dose of vaccine. And statistics for the first quarter of 1959 show an increase of 83 per cent in paralytic cases over the same period a year ago. Frankly, health and medical authorities fear that these facts constitute an invitation to epidemic disaster like the one in Detroit last year.

The American Medical Association, United States Public Health Service and the National Foundation have all agreed that community action offers the only real hope for the fullest possible protection of the public.

The cooperation of physicians is urgently sought to insure maximum protection for individuals, families and communities.

Local methods to reach the unvaccinated must be worked out by local leaders—physicians included.

This is a last minute call for action. The summer months are upon us. Let not Wisconsin accept an invitation to disaster.

Woman Doctor's Ingenuity Disclosed in Letter

SECTION ON MEDICAL HISTORY

Recently the State Medical Society received another great collection of manuscripts and other memorabilia from Dr. Elizabeth Comstock of Arcadia.

Included was a letter from a good friend, Dr. Irene Tognanzini, dated December 7, 1920. At the time Doctor Tognanzini was at the American Women's Hospital in war-torn Serbia. The following are excerpts from that letter:

". . . I arrived here to my station about the end of March. . . . I was called the chief from that moment on and there has been little time to sleep at the switch. . . . The present capacity is about fifty beds . . . and needless to say their idea of a hospital and the American one differs within a most wide range. . . .

". . . The (hospital) building is a two story Turkish house with large rooms and many windows . . . there was soon one grand house cleaning, beginning from ceiling to floors. White washing is the local paint and it serves a very good purpose, and it was not long before the entire house was spotless. New straw in the bed ticks. All blankets had been washed and boiled. Then I started out to have the yard cleaned up and that was no easy task as they have no sewage system and the old filthy cess pool is the problem. I found the ground flooded within very close range of the house. And thus the work continued until things were fairly presentable.

"Then I began to admit patients and there were scores that certainly needed hospital care. Operative cases presented themselves and I did not stop because I was without instruments. There were a few very old and simple ones in the place. So I had to invent.

"There were no retractors so I betook myself to the village stores and purchased a few very crude eating forks. There was no choice. I took them to the blacksmith and had him pound them into shape. And the result was that I got a few twisted into the retractor type. . . . Then I had no ether mask and finding a few stray tea strainers I proceeded to give them a twist that turned them also into a mask. . . .

"One day I had an osteomyelitis of the tibia to do and behold there was no chisel nor mallet. I betook myself to the wood pile and soon found two pieces of wood that were united and changed into a very good mallet. Then for the chisel. I was at sea for a moment when was inspired that the carpenter might have one and like an inspiration in an emergency it was correct, and thus I soon had the necessary tools. Did a radical for such an ailment. And the child has regained a good leg. . . .

"We have been terribly short of all kinds of supplies. The most essentials have been a minus quantity. But we managed. If I ever again work with a full and complete outfit, I will not know how to act. There was a great deal of substitution as it was either that or nothing. It has only been within the last few months that we have a sterilizer. And the local baker oven baked our surgical dressings as well as he could. Then often we operated with all boiled dressings. Can you imagine draping a patient for an abdominal with wet sheets. Well, it works and mine were liked by the good Lord as they escaped all pulmonary troubles. Often I have felt more as if I were in the steam laundry than in an operating room. . . .

"I have done all sorts of cases and still am having very good cases come in. The surgery has been very heavy ever since we took the hospital over. Have had a great deal of war surgery as the bandits are every day attacking the natives. And we have all sorts of gunshot cases, some of them very grave. Have had several amputations and all else that goes along with gunshot fractures and wounds. . . .

". . . Talk about malaria, it exists in the most grave state and catches them one and all. Even the small babies often are brought in as yellow as saffron, and practically bloodless. . . .

"Have learned quite a few Serbian words and can run a clinic and make the rounds without the interpreter. . . ."

THE MEDICAL FORUM

STATE AFFAIRS

SOCIETY SCENE

Annual Meeting

The 118th annual meeting of the State Medical Society was a historic occasion:

Its ties with the past were pointed up by a display of William Beaumont memorabilia which greeted each physician as he registered, by a display of world-wide postage stamps commemorating medicine and medical men, by lectures and exhibits on the far-flung advances in the healing art since time has been recorded.

Its tone was taken from Article II of the Society's seasoned Constitution: "To federate and bring into one compact organization the entire medical profession of the State of Wisconsin . . . to promote friendly intercourse among physicians; to enlighten and direct public opinion in regard to the great problems of state medicine. . ."

Its trials—to the chagrin of the news reporters—never broke into the open and were marked with care, dignity and "progress".

Its tributes went to men who had helped shape state medical history: eleven new members of the 50 Year Club, two distinguished teachers and scientists, and a layman who had played a vital role in industrial health.

These were the elements that prevailed.

COUNCIL REPORT

Keogh–Simpson Bill

On Monday evening Dr. James C. Fox, Council chairman, submitted a supplementary report to the House of Delegates on the results of Council meetings the day before.

No progress had been made, said the chairman, toward changing annual meetings to the fall of the year. Basic difficulty: the Milwaukee auditorium and various hotels are already booked up in the immediate future.

The Council proposed a petition to Wisconsin's U. S. senators to back H. R. 10, the Keogh–Simpson bill before Congress. The bill, already passed by the house of representatives, would provide for deferred compensation of self-employed professionals.

Delegates approved and signed the petition.

Commission on State Departments

At the first session, the Council announced the following elections to its Commission on State Departments for the ensuing years:

Dr. T. W. Tormey, Jr., Madison, General Chairman, and the following Division Chairmen:

Dr. James Nellen, Green Bay, Crippled Children; Dr. A. M. Hutter, Fond du Lac, Geriatrics; Dr. G. S. Kilkenny, Milwaukee, Maternal and Child Welfare; Dr. E. D. Schwade, Milwaukee, Nervous and Mental Diseases; Dr. H. W. Carey, Lancaster, Public Assistance; Dr. Ray Piaskoski, Wood, Rehabilitation; Dr. Dayton Hinke, Richland Center, Safe Transportation; Dr. L. M. Simonson, Sheboygan, School Health; Dr. H. A. Anderson, Stevens Point, Chest Diseases; Dr. Meyer Fox, Milwaukee, Visual and Hearing Defects.

Medical Care Plans

The Council advised the Wisconsin delegation to the AMA to "stand vigorously" on the free-choice-of-physician principle over the closed panel system.

Hospital Relations

Troubled by the overlapping jurisdiction and responsibility of several Society committees concerning hospital relations and medical education, the Council made a special report on the matter and concluded that such committees ought to be dissolved and a new all-embracing Commission on Hospital Relations and Medical Education created. The House approved and President Hildebrand made the following appointments to the new commission:

Dr. R. S. Gearhart, Madison, chairman; Dr. S. R. Beatty, Neenah; Dr. J. W. Boren, Marinette; Dr. N. A. Bonner, Manitowoc; Dr. C. J. Picard, Superior; Dr. T. L. Squier, Milwaukee; Dr. J. P. McCann, La Crosse; Dr. T. H. McDonell, Waukesha; Dr. O. M. Overman, Neillsville.

The Council reelected Dr. Tiber J. Greenwalt, Milwaukee, as SMS representative to the North Central District Blood Bank Clearing House.

HOUSE OF DELEGATES
A historic occasion.

ANNUAL MEETING

PRESIDENT'S ADDRESS

". . . Of Grave Concern"

Dr. William B. Hildebrand began his presidental speech at the first session of the House of Delegates by spelling out a mission to carry the story of medicine across the state.

In the coming year he will concentrate on "three geographical as well as sociological areas . . .": county medical societies, service clubs and community groups, and state-level organizations.

Having finished his preliminary remarks, Dr. Hildebrand swung into the main theme: "a matter of grave concern to us all . . ."

Great struggle. Today, said he, we are living in an era of great struggle: East against West, liberal against conservative, labor against capital, democracy against dictatorship.

Of immediate concern to physicians, said Dr. Hildebrand, is "a concerted effort by numerous lay interests, in and out of Wisconsin, whereby these interests wish to assume control of the practices of medicine."

"This is *our* problem," he stressed.

"I believe firmly that the unlimited choice of physician, the free selection of patients, the unqualified responsibility of physician to patient, without the interposition of a third party, the unhampered exercise of professional judgment, and the direct reward for individual initiative, form the only possible basis for acceptable medical care of and by free men . . ."

Opposed to individual initiative as practiced by medicine are the well-organized lay groups, said Dr. Hildebrand, and they have one thing in common:

Impersonally ruthless. "They are not persons or individuals. Therefore, these organizations as such have no souls; they have no consciences; they cannot exercise professional judgment; they are governed by group (not individual) decisions, and they are impersonally ruthless.

Stating that these organizations are undoubtedly well-meaning, Dr. Hildebrand nevertheless cited ominous illustrations of the broad trends ahead:

In industry: the Kaiser medical service plan with its own hospital facilities for employees and dependents, staffed by salaried and closed-panel groups of physicians.

In labor: the United Mine Workers which has established the same system as Kaiser.

In government: the Veterans Administration providing care and medical service for an ever-increasing number of non-service-connected disabilities. Also ahead: the Forand bill with its "sinister implications."

In hospitals: a California institution now forbids the medical staff to meet for even a social gathering unless the administrator is present.

PRESIDENT HILDEBRAND
Unlimited choice . . .

In Wisconsin: one voluntary private nonprofit hospital is reported as currently employing department heads at a reputed salary of $10,000 each and may expand the idea.

To the question of whether lay control of medicine is on the advance in Wisconsin, President Hildebrand pointed to two current bills up before legislature: 129, A, the hired-physician and fee-splitting proposal by the Wisconsin Hospital Association, and 485, A, sponsored by Blue Cross, which would drive the medical profession out of the sale of insurance for hospital services.

How has the medical profession responded to lay encrouchments? ". . . Like a flock of stupid chickens under the shadow of the wing of the hawk."

No Munich for medicine. For Dr. Hildebrand there would be no Munich for medicine: "The time for apologies and defense has passed. We must take the offensive. We must use our minds and our hearts and our hands to determine what is best for those we serve—our patients—and what is best for the medical profession . . ."

Dr. Hildebrand, in a study of what is ahead, came to five conclusions:

1. The economic and social order today is largely controlled by highly organized pressure groups, and it won't change.
2. . . . "As we stand idly by," the rights, privileges and immunities of medicine are being bargained away by labor, industry, government, insurance companies, hospitals.
3. Wisconsin medicine must create its own offensive program to combat the trends.
4. The SMS and WHA, if the power struggle continues, will both weaken and fall prey to powerful regulatory forces.
5. Instead, doctors and hospitals must unite to provide the best possible care for the needy and the ill, at costs within their reach; each group staying within its traditional sphere of influence and activity.

The attack. To meet the attack, Dr. Hiledbrand proposed a permanent Society commission of "level-headed . . . astute . . . dedicated . . . most courageous men" to plan a defense and offensive program to preserve the private practices of medicine in Wisconsin.

"We shall find a way," quoted Dr. Hildebrand, "or make one."

COUNCIL

County—State Relations

At Tuesday's session of the House the Council reported that the Committee authorized by it and appointed by the President of the Society, and a committee appointed by the President of the Medical Society of Milwaukee County, had met to discuss the problems between the two Societies.

Future meetings will be held with a view to providing appropriate recommendations for the settlement of these problems as quickly as possible.

ANNUAL MEETING

HONORS

For Distinguished Service

Dr. Raymond G. Arveson, 76, Frederic, has served long and well in the highest posts of the SMS: as President (1939–40), Councilor (1942–59) and as Chairman of the Council (1948–59.)

He has earned the coveted Council Award. To show its additional appreciation for distinguished service, the Council has elected Dr. Arveson to honorary membership in the Society. He becomes one of only 14 individuals holding that status.

ELECTIONS

New SMS Officers

By unanimous vote the House of Delegates in its final session elected Dr. Edmund D. Sorenson of Elkhorn as SMS president for 1960–61.

The president-elect is a GP with a special interest in obstetrics. Native-born Dr. Sorenson, 64, was graduated from Marquette University's Medical School in 1924.

He has served as chairman of the SMS Grievance Committee for 15 years and a number of times as member and chairman of the House Reference Committee on Resolutions and Constitution and Bylaws.

Other election results:

Speaker of the House of Delegates:
Dr. L. H. **Lokvam**, Kenosha

Vice Speaker:
Dr. N. A. **McGreane**, Darlington

Delegates to the AMA (to take office Jan. 1, 1960):
Dr. A. A. **Quisling**, Madison
Dr. R. E. **Galasinski**, Milwaukee
(In a touching speech, able Dr. W. D. Stovall, long-time AMA delegate, had told the House that he would step aside.)

Alternate Delegates to the AMA:
Dr. William B. **Hildebrand**, Menasha
Dr. George **Collentine, Jr.**, Milwaukee

New Councilors:
Dr. James C. **Fox**, La Crosse, Seventh District
Dr. J. M. **Bell**, Marinette, Eighth District
Dr. R. W. **Mason**, Marshfield, Ninth District
Dr. Ralph C. **Frank**, Eau Claire, Tenth District
Drs. W. J. **Egan** and J. W. **Fons**, both of Milwaukee, Twelfth District
Dr. W. P. **Curran**, Antigo, Thirteenth District

AUXILIARY

Writing on the Wall

Mrs. Gordon Schulz, president of the Auxiliary, had some pleasant news to give the House of Delegates.

From the membership of 1,700 came a gift of $1,000 for the Charitable, Scientific and Educational Foundation and another $4,100 for medical schools.

PRESIDENT-ELECT SORENSON
. . . and unanimous vote.

In reporting on these and other successful projects, Mrs. Schulz proudly declared: "We are your Auxiliary. We wish you would request more of our services."

But she couldn't help interject a note on current medical-hospital relations. At the present time, said Mrs. Schultz, the popular vogue is the hospital auxiliary. Many of the Medical Auxiliary are becoming more interested in the hospital counterpart than their own.

"We need them." "But only doctors' wives may belong to our Auxiliary, and we need them," she continued. "So far, it hasn't made a great deal of difference in our membership or projects, but I can see the writing on the wall . . ."

At the end of her report gracious Mrs. Schulz introduced to the House the equally-gracious President-elect, Mrs. G. A. Behnke, Kaukauna.

FINANCES

In Good State

Dr. F. L. Weston, SMS Treasurer, delivered a brief report on the state of Society finances for 1958. It was good: Net worth (includes Wisconsin Medical Journal and surpluses in General Fund, reserve for new building and reserve for Section on Medical History): $119,726.66.

General Fund Income	$291,820.47
Total Net Expenses	291,074.59
Excess of Income over Expense	745.88

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SMS FOUNDATION

President's Report

Soft-spoken Dr. William D. Stovall, president of the Charitable, Educational and Scientific Foundation, was not so soft-spoken as he addressed the House on Monday night.

But he was lucid as ever: Is the Foundation just another do-good organization? "Of course it is . . . that is all medicine is about, anyhow—doing good!"

Yet the good that is being done is far less than it should be. The scalpel-sharp reason: only 600 physicians in Wisconsin last year made the regular $10 voluntary contribution to the Foundation.

Dr. Stovall stated that $55,000 is now out on loan to medical students, but there is no money left to fill standing requests from needy students.

A challenge. Challenging the physicians to give more, he pointed out that the government is handing out scholarships left and right.

But, he said, "you are the ones who want to make an impact. You want to have men practicing medicine who can represent the ideals and the standards that you have. We can determine that by selecting those to whom we give help in getting their medical education."

Another reason for the Foundation: to help physicians in need. "Sure, let the government do it," taunted Dr. Stovall.

And "We need money for our museum. How are we going to portray to the public what the position of medicine is in the social order unless we do it through education?"

The challenge was unmistakable. And to help meet it the House recommended a voluntary assessment of $10 on each state physician, along with additional amounts from those who could afford it.

At the Foundation's annual luncheon on Wednesday, attended by about 35 trustees, there was a gift of $1,000 for the student loan fund from the Auxiliary.

A resolution. At the same time a resolution was adopted urging county medical societies to utilize their reserve funds to support the student loan programs of the Foundation.

An adequate medical student loan account should total $250,000, it was determined.

A grant. A $500 grant was accepted from the Wisconsin Council for Mentally Retarded Children for postgraduate education.

At the meeting the trustees, impressed by the success of the statewide athletic injuries conference last fall, authorized similar regional institutes on an annual basis.

The Foundation also authorized the appointment of a committee on the American Medical Education Fund, with Dr. A. H. Heidner, West Bend, as chairman.

An election. All principal officers were reelected: Dr. Stovall, President; Dr. A. J. McCarey, Green Bay, Vice President; Dr. Gordon Schulz, Union Grove, Treasurer.

Dr. Elizabeth Comstock, Arcadia, was elected honorary Vice President.

Henceforth, a quarterly report will be made to all trustees on all activities of the Foundation, and each trustee has been asked to make an annual report to his county medical society.

DRS. COMSTOCK & STOVALL
A scalpel-sharp reason . . .

APPOINTMENTS

Standing Committees

At the final session of the House President Hildebrand announced the following appointments:

Committee on Cancer: Six terms expiring. Reappointed Dr. Ralph C. Frank, Eau Claire; Dr. Gerald I. Uhrich, La Crosse; appointed Dr. Roy C. Glise, Richland Center; Dr. Glenn A. Smiley of Delavan; Dr. Joseph J. Gramling, Jr., Milwaukee; Dr. John F. Brown, Rhinelander; appointed Dr. Paul M. Cunningham, Appleton, chairman.

Committee on Grievances: Three terms expiring. Reappointed Dr. E. D. Sorenson, Elkhorn; Dr. Elwood W. Mason, Milwaukee; appointed Dr. Robert W. Mason, Marshfield; appointed Dr. Eugene J. Nordby, Madison, chairman.

Council on Medical Services: Three terms expiring. Reappointed Dr. Charles J. Picard, Superior; appointed Dr. Howard M. Templeton, Barron; Dr. William E. Acheson, Valders; reappointed Dr. Donald M. Willison, Eau Claire, chairman.

Committee on Public Policy: One term expiring. Appointed Dr. Norbert Enzer, Milwaukee; reappointed Dr. A. A. Quisling, Madison, chairman.

Council on Scientific Work: One term expiring. Appointed Dr. A. R. Curreri, Madison. It is a tradition that the Council selects its own chairman.

RESOLUTIONS

Final Report

Report of the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws led the House to take the following actions:

Resolution 1 & 2 (Trempealeau, Jackson, Buffalo County Medical Society; Racine County Medical Society): That a membership poll be taken of the SMS on the question of whether physicians favor com-

pulsory social security. Committee recommendation: conduct the poll, with certain explanatory information going to each physician; the results to be considered "informative" only for AMA delegates and SMS delegates. House action: approved.

Resolution 3 (Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Medical Societies): That a single Blue Shield plan be devised for the state, operated by a revamped Commission on Medical Care Plans. Withdrawn by the authors.

Resolution 4 (Manitowoc County Medical Society): That Article II of the Constitution, which spells out the purpose of the Society (unity among physicians for better medicine), be read at all SMS meetings. Committee recommendation: first sessions of House of Delegates could begin the practice. House action: approved.

Resolution 5 (Manitowoc County Medical Society): That the SMS secretary be a physician. Committee recommendation: that the matter be referred to the President's Advisory Committee on the Study of the Constitution and Bylaws because of the "difficulty in correlating the duties of a physician secretary as outlined in Chapter V, Section 4." The referral is "not to be construed as expression of lack of recognition of the motivation and efforts of the current secretary of the Society." House action: approved.

Resolution of the Washington–Ozaukee County Medical Society: That separate and distinct Ozaukee and Washington County Medical Societies be formed from the present unit. Committee recommendation: yes. House action: approved.

The following resolutions were considered by the Reference Committee on Reports of Officers:

Resolution 6 (Douglas County Medical Society): That the use of county facilities for treatment of tuberculosis be studied by the Division on Chest Diseases, State Board of Health and Legislative Council. Committee recommendation: yes; Division on Chest Diseases has already started the study; but matter shouldn't be taken to Legislative Council until specific recommendations are made. House action: approved.

DRS. BECKMAN & FOX
. . . and a rare combination.

Resolution 7 (Douglas County Medical Society): That authority of State Board of Health be strengthened regarding treatment programs in county facilities for tuberculosis. Committee recommendation: yes, with SMS preparing legislation to the effect that all institutions receiving state aids for treatment of t.b. shall operate under SBH authority pursuant to Chapter 50, Statutes. House action: approved.

Resolution 8 (Douglas County Medical Society): That Parkland Hospital in Douglas County be closed, with all patients going to other facilities which offer proper psychiatric care for t.b. patients afflicted with mental disease. Committee recommendation: psychiatric t.b. patients should be transferred to establishments affording mental treatment, but further use of the Douglas County facility is rightful prerogative of that county. House action: approved.

HONORS

The Selected Few

Each year the SMS selects a few men, who, by their meritorious conduct, have set an example for medicine and public health in Wisconsin.

The annual banquet was the occasion this year for honors awards.

The **Council Award,** highest that the Society can bestow, went to Dr. Harry **Beckman**, 67, of Milwaukee. Professor and director of pharmacology, Dr. Beckman has been a member of Marquette University's Medical School for over three decades.

The award cited Dr. Beckman "for your unfailing loyalty and devotion to the practice of medicine, for the rare combination of humility, skepticism and questing mind which has made you one of America's great medical scholars, for your admirable ability to trans-

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fer your own knowledge and idealism to young men and women entering the noble profession of medicine; for your eternal contributions to medical science as inquirer, author, tutor and advisor. . ."

To layman **Reuben G. Knutson**, Madison, chairman of the State Industrial Commission where he has served almost 20 years, went the Society's first **Presidential Citation.**

The award commended Knutson for his ". . . selfless and distinguished career in the public interest, for his leadership in the establishment of the famed Wisconsin open panel free choice system, for his understanding of medicine and the health needs of the workman, for his outstanding service as commissioner and chairman of the State Industrial Commission. . ."

For Dr. William Davison **Stovall** who has carved such a high niche in Society history, there was the plaque which will crest the **Stovall Memorial Gateway** to SMS headquarters. ". . . Distinguished physician, scientist, teacher, medical statesman who has dedicated his life to human welfare . . ." it read in part.

Dr. Stovall, in accepting the brass plaque, gazed over the audience for a moment, then drew a pointed parallel between the physicians' annual banquet and the old German folktale of the village that re-appeared once every 100 years for a night of merriment and gaiety.

"This is our night," exclaimed Dr. Stovall, "our night to celebrate. Thank you for the honors you have heaped upon me. And I shall be with you on this night as long as I live!"

Eleven Wisconsin men of medicine who, together, have practiced the art of healing for a total of five and a half centuries, were signally honored.

Admitted to the exclusive **50 Year Club** were:

Dr. Frederick A. **Davis**, 76, Madison;
Dr. Gustave E. **Eck**, 73, Lake Mills;
Dr. V. E. **Ekblad**, 73, Superior;
Dr. H. P. **Greeley**, 75, Madison;
Dr. George T. **Hegner**, 72, Appleton;
Dr. William C. **Liefert**, 74, Milwaukee;
Dr. Edmund H. **Mensing**, 73, Milwaukee;
Dr. Fred J. **Pfeifer**, 70, New London;
Dr. George A. **Steele**, 77, Oshkosh;
Dr. Guy F. **Wakefield**, 76, West Salem;
Dr. Arthur J. **Wiesender**, 77, Berlin.

All but three were able to attend.

HONORS

Surprise Party

Dr. Albion H. Heidner, West Bend, knew "something funny" had been going on recently, but he was completely surprised to find out that he was guest of honor at a special SMS dinner in his hometown two nights before the annual meeting.

SMS officers had assembled a host of fellow physicians, relatives and friends to pay homage to a man who has been a Councilor of the Society for 28 years (1929–34 and 1936–58), past President (1951–52), and guiding hand in many a medical policy.

An added surprise was the appearance of Gov. Gaylord A. Nelson, who made an unscheduled call to express his best wishes to Dr. Heidner.

Dr. James C. Fox, Chairman of the Council, delivered a tribute to "Dr. Heidner's contributions to his community, to his professional colleagues and to the public health of Wisconsin."

"It is given to but few men to have participated so long and so fruitfully in the affairs of his fellow men," Dr. Fox said.

As a memento of the evening and of his service to medicine, Dr. Heidner was presented with his special chair as "5th District Councilor of the State Medical Society."

EXHIBITS

Photography Winners

At the banquet Wednesday evening five physicians were named as winners in the photography exhibit sponsored by the Section on Medical History. Their photographs, together with other entries, were hung on display at the Hotel Schroeder.

Dr. W. L. **Waskow**, Madison, took **First Prize** with an impressionistic photograph of paranoia. His photograph won in the class illustrating physicians in research and in teaching.

Honorable mentions:

1. Dr. A. J. **Quick**, Milwaukee, for a picture of historic Tenna, Switzerland, where the first known carrier of hemophilia lived in 1667.
2. Dr. R. H. **Ludden**, Madison, for a picture of a medical civil defense team in action.
3. Dr. L. W. **Schrank**, Waupun, for a photo of a physician bucking last winter's snowdrifts to make his rounds.
4. Dr. E. G. **Schott**, Sheboygan, who portrayed physicians in recreational activity with a photograph of a doctor's bowling team.

The exhibit will be held again next year.

ANNUAL MEETING

REPORTS

On Officers

The House approved the following recommendations of the Reference Committee on Reports of Officers:

¶ A recommendation from **President Hildebrand** that the SMS undertake the task of planning an immediate and long-range offensive program to preserve the private practice of medicine in Wisconsin. The House asked that this plan be implemented through the Council.

¶ A recommendation from the **Division on School Health** that a guide on immunization practices be published and circulated to all state physicians and others engaged in the field of school health. The Division also suggested a fourth Salk booster injection if more than two years have elapsed since the third.

¶ A recommendation to change the name of the **Division on Geriatrics** to **Division on Aging**; and that county societies and the SMS take an active part in local, state and national conferences on the problems of aging.

¶ A report from the **Division on Chest Diseases** that it concentrate its efforts largely on the programs of the use of mobile units, the study of t.b. and the dual use of sanitaria facilities.

¶ A report that the **Division of Visual and Hearing Defects** is encouraging the promotion of present standards of testing by motor vehicle authorities.

¶ A report from the **Division on Nervous and Mental Diseases** recommending clarification of the interpretation of "insanity before law."; an early report on tranquilizers in the *Wisconsin Medical Journal;* recommending physicians work actively with lay groups for mental health, but that these groups not be permitted to merely use the doctor's name if his services are not actually used; recommending that the study of the "second injury clause" be actively pursued to eliminate inequities in the present law.

¶ A report from Mrs. Gordon **Schulz, Auxiliary** president, that county medical societies utilize the "extremely active and valuable help that our ladies are so anxious and able to give us."

REPORTS

On Standing Committees

The House approved the following recommendations of the Reference Committee on Reports of Standing Committees:

¶ A recommendation that the chairman of the **Committee on Industrial Health** be a member of the **Council on Medical Service.**

¶ A commendation to the Council for completion of its Medical–Press Guide, soon to be distributed to physicians and the news media.

¶ A recommendation that the **Committee on Industrial Health** encourage industry to appoint community physicians to guide them in medical matters, employment examinations, safeguards in the use of narcotics, health and safety programs.

¶ A call for continued attention to problems of locating physicians for rural communities and the development of closer liaison with rural and farm groups.

¶ Endorsement of plans of the **Council on Scientific Work** to provide county medical societies with scientific programs financed through the SMS Foundation.

¶ A suggestion that county society meetings be balanced between scientific and socio-economic matters, perhaps separate meetings on each.

¶ A commendation to the **Committee on Civil Defense** for its continued efforts, and to Dr. C. N. **Neupert** and the State Board of Health.

¶ A "deep debt of gratitude" to the **Committee on Public Policy** for day to day activities in legislation. "Their awareness of critical importance of certain legislation to the public health and to the preservation of high standards of medical care is of no value unless it reaches the members of the Legislature. Our failure to do so at the county and individual level, to quote the comment of the Committee on Public Policy, 'carries the probability of severe penalty. That penalty, of course, is punitive or thoughtless legislation resulting from ignorance of those facts.' "

¶ An apprasal that the work accomplished during the past year by the field service to medical staffs of hospitals has been an excellent beginning and carries with it an unusual challange for the future. The Committee wished to stress the fact "that the activities of the Hospital Relations Consultant are thoroughly and continuously supervised by the **Committee on Hospital Relations** and the executive staff of the SMS.

¶ A suggestion that each delegate examine the adequacy of local medical staff bylaws and bring them up to date to provide a foundation of proper conduct of the medical staff and the basic relationship to hospital administration.

¶ A recommendation that the SMS undertake specific programs aimed at interesting eligible young people in careers in medicine and allied health fields; and that each county society conduct an annual program for young men and women to inform them of the opportunities in medical practice and the function of the physician in the community.

50 YEAR CLUB: (seated) Drs. Davis, Ekblad, Greeley, Hegner; (standing) Drs. Liefert, Pfeifer, Steele, Wiesender.

AMA

Thinking Ahead 100 Years

A president of the AMA represents to the public all of organized medicine in the United States.

Within the AMA he represents something more: he is the product of all organized medicine in his home state, and more or less on the spot for its conduct.

As AMA president Dr. Gunnar Gundersen began his annual banquet address Wednesday night he had a few words to say of Wisconsin's conduct: "I am deeply impressed with the things you are doing here." He cited the work of the SMS Foundation as one example.

Then: "I have visited many state societies in the past year, yet I know of no society which is assuming leadership the way this society is!"

But when he got to the subject of low-cost voluntary health insurance for the aged, with which his tenure of office will always be associated, President Gundersen really beamed with pride over Wisconsin's conduct.

He noted that the SMS had its insurance for the aged in operation in less than five months after the AMA proposal last December.

Century Plan. "And when you named your plan the Century Plan," said Dr. Gundersen, "you were thinking ahead a hundred years!"

The subject proved to be the theme of his address. Dr. Gundersen pointed out that in Benjamin Franklin's day the average lifespan was 35 years. Now it is more than twice that much. Today, he said, one out of every 11 citizens are past 65. By 1980 it will be one out of seven.

But advanced age poses new problems, he went on, and because medicine is indirectly responsible, it has an obligation to try to solve them.

"Certainly, health care for the aged is one of our most urgent challenges. But where an urgency exists, I believe an opportunity also lies . . . opportunity awaits he who will conquer the urgency."

Dr. Gundersen commended U. S. medicine for seizing opportunity and developing a program for low cost aged insurance.

He stated, "It is rooted in the traditional American concept of *voluntary* action by the individual.

PRESIDENT GUNDERSEN
More than lip service.

There is no *compulsion*, no financial burden on others, no dependency on the government, no drain of tax funds."

"A foolish philosophy." Because of such concrete steps to provide needed help in the health insurance field, said Dr. Gundersen, medicine will oppose the . . . "foolish philosophy of 'pass-a-law-and-raise-the-social-security-tax-again.' "

But, he stated in conclusion: "Regardless of how fine a plan we develop, regardless of how enthusiastically we talk about it, its success, and the success of the American medical profession, depends on what you and I *do* about it. If our plan is to succeed, if medicine is to earn the gratitude of the nation's aged and of the future generations of senior citizens, each one of us must do more than pay lip service.

You and I must make this plan work!"

TRAFFIC SAFETY

Teenage Program

The Division of Safe Transportation, noted in its annual report that the physician is challenged "to project his status into the wider function of medical counselor to the whole field of road safety."

Believing that "driver attitude" is in large measure responsible for motor vehicle collisions, and that "driver attitude" can best be influenced in the early years of life, the Division recommended a statewide safe driving program aimed at teenagers.

Heart of the program would be a "safe driving slogan of the month" with monthly awards to the winning youngsters and their schools.

The House approved of the program.

BOARD OF HEALTH

Executive Report

Dr. Carl N. Neupert, State Health Officer, in his report to the House, praised the cooperation that exists between his agency of government and the individual physicians in the state.

It results, said he, "in accomplishments in the public interest that could not be expected were we to try to do them separately. Your patients (the people of the State) and the Board continue to be deeply indebted for this devotion to the advancement of that essential ingredient—health."

MEDICAL SCHOOLS

The Deans Report

Dr. John S. Hirschboeck, Dean of Marquette's Medical School, discussed the problem of who should control health services in his address before the House.

His suggestion: ". . . A single unified health service corporation, not controlled by the physicians or the hospitals alone, but by both, with substantial support and representation by the consumers."

In his House address, Dr. John Z. Bowers, Wisconsin's Medical School Dean, stated: "All reports and surveys at the national level indicated that the Medical School in Madison stands among the first ten in the country, but neither you nor I would be content to leave things as they are. Medicine is changing. The country is changing, and we must change with it."

MEDICAL EXAMINERS

State Board Report

Secretary of the State Board of Medical Examiners, Dr. T. W. Tormey, Jr., had some interesting statistics to report to the House for the past year.

A sampler: 190 candidates were examined for license in medicine and surgery by written examination; 180 by reciprocity. Ten foreign applicants were licensed in 1958 and six in 1959, out of a total of 46 considered.

Number of physicians registered for 1959 is 5,042, while 4,180 of these are listed as practicing in Wisconsin.

THE WISCONSIN MEDICAL JOURNAL

Volume 58 JUNE 1959 Number 6

President's Message to the House of Delegates*

By W. B. HILDEBRAND, M. D.

Menasha, Wisconsin

DRAMATIC BUT unfortunate events occurring during the special session of the House of Delegates of the State Medical Society of Wisconsin in Stevens Point last September, catapulted the President-elect of the Society into the Presidency, which was officially assumed by him on November 1, 1958, six months before his elected term was to have begun. Because of the suddenness of the responsibility placed upon him, a rather rapid change of his plans was necessary in order that the programs and goals timetabled for 1959–1960 could be initiated earlier.

Your President felt that he could best carry out duties of his office if he would take the story of medicine into three geographical as well as sociological areas in the State of Wisconsin.

1. To county medical societies by bringing to as many as time would permit, an analysis of what the State Medical Society is doing for the membership, for medicine and public health, and how each is accomplished.
2. To service clubs, community groups and other local interested organizations by presenting the story of medicine in Wisconsin in an address entitled, "The Best Health Buy for All Badgers". Such presentations are to be timed with an appearance before a county medical society, usually on the same evening.
3. To other organizations on a State level, such as the Wisconsin Hospital Association, the Wisconsin Nurses Association, the Wisconsin Pharmaceutical Association, the Wisconsin American Legion, and the Wisconsin Congress of Parents

For some of my remarks I am indebted to three men: Dr. Walter Abbott, immediate past president of the Iowa State Medical Society; Dr. John Galivan, the incumbent president of the Medical Society of the State of Connecticut; and Dr. Westbrook Murphy, past president of the Medical Society of the State of North Carolina, whose respective state organizations found themselves, a few years ago, in precisely the same spot which Wisconsin medicine stands today. I want to pay tribute to those men who have inspired me for some of the thoughts I wish to present to you.

* Presented before the House of Delegates at the One Hundred Eighteenth Annual Meeting of the State Medical Society, May 4, 1959, Milwaukee.

and Teachers, to name a few, by bringing to these groups the story of Wisconsin medicine on a broader concept, dealing with the current problems of the type common to both medicine and the groups addressed, each address tailored to fit the needs of the individual group.

All of these presentations were designed with one thought in mind, that of furthering and fostering professional public relations in the State of Wisconsin, both intra- and extra-professional in nature, which I am sorry to say need considerable attention.

Although in a more limited way than desirable, the above objectives have been carried out and will be expanded during the year 1959–1960 within the limits of time and opportunity.

Duties of the President

The office of the President of your Society is a frustating one. It is a full-time job operated on a part-time basis. The President first and foremost must be a practitioner of medicine, and such is his primary responsibility; and yet as an ex officio member of all committees, he must attend as many of their meetings as possible, sharing with them their discussions and their decisions. In addition, he must be the ambassador and the emissary of the Society in its relations with similar groups outside the State, the American Medical Association, and other allied professional and nonprofessional groups within the State.

Conferences, attendance at committee meetings, telephone consultations with members of committees and with the executive staff, preparation and presentation of addresses, visiting other state medical societies, initiating and answering correspondence, attempts to placate and satisfy disgruntled members, all are time- and energy-consuming.

Your President shares the feeling expressed by some Presidents who have gone before, that the multiplicity of duties and appearances does not add up to very much in the way of contribution toward the successful operation of our Society. Such, however, is the way it is, and such is probably the way, under our present structure, that it will continue to be.

May I digress for a moment to pay thanks and give credit, for both are due. The staff of the Society headquarters is working smoothly, and each employee is giving his or her best toward the over-all cooperative effort. No question or request put to them, however trivial, is ignored, and all are answered with dispatch.

I am proud to say that the relationships of my office with the headquarters staff have been pleasant, fruitful and satisfying. Events of the past few months have caused great sacrifices in the personal lives of many of the staff, especially at the top level, and our Society should feel deeply grateful for their outstanding performances under a great deal of stress.

It should not be within the province of these remarks to elaborate upon the Council, committee or commission reports which are before you and which you have undoubtedly read. Suffice it to say that the Society owes a tremendous debt to many active and dedicated doctors of medicine in our Society, who give so much of their time and effort toward the solution of problems confronting their various committees and commissions. The fruits of their labors of the past year have been presented to you in the committee and commission reports which are up for consideration before this House of Delegates.

Now, the primary purposes of the State Medical Society, as stated in Article II of our Constitution, are:

> "To federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life."

Members of the House of Delegates, you can be assured that through the various activities of our Society such is being accomplished.

It is, however, pertinent that attention be given to three committees, appointed by the President and now currently engaged in their deliberations, which are a direct result of events transpiring in attitudes expressed last May and last September at the sessions of the House of Delegates in Milwaukee and Stevens

Point. All three of these committees have been thoroughly discussed at Council meetings, and both have complete Council action and approval.

The first of these is the President's Study Committee on the Structure and Operation of the Wisconsin State Medical Society. This Committee is currently conducting a thorough analysis of our entire operation, to report at length in May of 1960 at the annual session. A meeting of this Committee will be held during this session of the House of Delegates, to which any and all members are invited, and before which they may express their views.

The second committee is a Liaison Committee, between the Board of Directors of the State Medical Society of Wisconsin and the Board of Directors of The Medical Society of Milwaukee County, which has the sanction and approval of both groups.

This Committee is charged with and is currently studying, on all levels, ways and means of ending the longstanding differences which exist between the Wisconsin State Medical Society and the Milwaukee County Medical Society, and most pressing, of course, being that of the Surgical Care–Wisconsin Physicians Service controversy. No later than this noon this Committee met; and I am happy to report that, although progress is slow, progress is being made.

The third committee appointed consists of the Committee on Public Policy of the State Medical Society and appointed members of the Board of Directors of the Wisconsin Hospital Association. This Liaison Committee is currently discussing and will continue to discuss ways and means of agreement in many disputed fields of physician-hospital relationships. Such a Committee, in my opinion, is long overdue, and already misunderstandings have been changed to understandings with respect to certain phases of physician-hospital problems.

After these preliminary remarks your President feels that it is his duty to devote the rest of the allotted time to call to the attention of the members of this House of Delegates, and through it to the entire membership of the State Medical Society, a matter of grave concern to us all.

There are ominous, unmistakable indications that strong, ruthless forces within and without Wisconsin are attempting to destroy the freedom of the private practice of medicine. May I say that I am not presenting an official view or position of either the Council or the State Medical Society itself on this subject. In making these remarks, I alone assume complete responsibility; and even though I shall dwell on certain physician-hospital relationships which are at present under discussion in the Liaison Committee previously mentioned, I have no criticism of Wisconsin hospitals or the service which they render as such. The local hospitals where I practice are entirely ethical. I have no conflict with them whatsoever, and our Wisconsin hospitals in general I believe to be serving the public with credit and distinction. I feel, however, that the matter to be discussed is the most important problem of any currently confronting Wisconsin medicine.

An Era of Struggle

We are living in an era of great struggle. The East is pitted against the West; the liberal is pitted against the conservative; Communism and Socialism are struggling against private enterprise, labor against capital; democracy against dictatorship, and Negro against Caucasian, and vice versa. But of immediate concern to us as physicians is a concerted effort by numerous lay interests, in and out of Wisconsin, whereby these interests wish to assume control of the practice of medicine. *This is our problem.* This struggle involves the previously mentioned lay interests and the medical profession.

I believe firmly that the unlimited choice of physician, the free selection of patients, the unqualified responsibility of physician to patient, without the interposition of a third party, the unhampered exercise of professional judgment, and the direct reward for individual initiative, form the only possible basis for acceptable medical care of and by free men. On every passing day these essential qualities are being degraded and the perimeter of private practice is being continually constricted.

Those who are about to destroy our system of practice fall into a number of diversified groups; but they have at least one thing in common as organizations, and this is very important—they are not persons or individuals. Therefore, these organizations as such have no souls; they have no consciences; they cannot exercise professional judgment; they are governed by group (not individual) decisions, and they are impersonallly ruthless.

These organizations of which I speak are undoubtedly well-meaning, and they operate behind screens of well-meaning laymen who, I believe, are largely unaware of their true objectives. Unfortunately, there are in the background physicians aiding and abetting these well-meaning laymen, in some instances, who do not comprehend the devastating end results of their policies.

Generally speaking, these groups of laymen are so well organized as to demand and secure conformity from their lesser component units.

There is nothing vindictive or punitive in their attitude toward medicine as such, but unfortunately the medical profession is being caught in the middle as we stand in the way of their expanding programs. The day is not far off, in my opinion, when these groups, consisting of labor, industry, government, insurance companies and, I am sorry to say, hospitals and related groups, will combine in their effort and their campaign to control all health activities. If medicine does not rise up into a position of strength, private practice as we have known it will cease to exist.

I would like to give you some illustrations and endeavor to make some observations which will convince you beyond reasonable doubt that the private practice of medicine in Wisconsin is in imminent danger of losing its status as a professional art, and is being forced into the mould of a trade. I should also like to give you some illustrations, occurring outside the State of Wisconsin, which certainly will prove the same thing.

Patient–Doctor Relationship

The very keystone of practice—the patient-doctor relationship, the respect of the patient for his doctor, and the influence of the doctor with his patient—is the primary target at which all of these concerted forceful attacks are being directed.

As illustrated by the Kaiser Medical Service Plan on the West Coast and the Atlantic Coast Line Railroad in Delaware, industry over the nation is building a series of hospitals and is organizing medical service plans, for their employees and their dependents, which are staffed by salaried and closed-panel groups of physicians.

Labor is also establishing and has established hospitals and complete medical service plans which have been staffed by salaried and closed-panel groups of physicians whereby total medical care is dispensed for their members and their dependents. The United Mine Workers are a specific example of such a move.

At a congressional hearing not long ago, Mr. Frederick F. Umbrey, who is associated with the International Ladies Garment Workers Union, complained of a lack of cooperation from physicians and recommended that the Sherman Antitrust Act be so amended as to include medical and hospital services.

Dr. Edwin F. Bailey, who is vice-president of the Health Insurance Plan of Greater New York, has predicted that organized labor will soon establish the pattern of medical care in the United States.

The Veterans Administration is providing hospital care and medical service for an ever-increasing number of nonservice-connected disabilities. It is not impossible that within the near future dependents of veterans will be included.

Medical and hospital care for federal employees and their dependents, and for members of the armed forces and their dependents, is being expanded at a tremendous pace. The use of federal funds for medical schools, hospitals and clinics has increased to an alarming degree, and the end is not in sight.

The vast social security system now provides cash payment and medical and remedial care for needy individuals 18 years of age or older when permanently and totally disabled.

The Forand Bill stands looming before us in all of its sinister implications, providing medical-surgical and hospital care to patients receiving social security who are over a certain age, whether permanently and totally disabled or not.

Immunizations and the diagnosis and treatment of tuberculosis rests now largely in the hands of public health departments. The belief that industrial medicine should be a health department activity is held by many officials.

These philosophies are not necessarily confined to medicine. There is reputed to be an active national organization of attorneys which undertakes to train its members in refuting medical testimony and in securing larger judgments in professional and other liability cases. Some of the bills introduced in the present session of the Legislature in Wisconsin have been encouraged by this organization.

The national organization of optometrists is asking for the passage of legislation which would, in effect, limit refractions to licensed optometrists. Ophthalmologists would therefore be required to secure such licenses.

I need not speak of the perennial chiropractic legislation, examples of which are before the present Wisconsin Legislature. Passage of such legislation is approval of cultism.

Now, it is quite evident to me that the American Hospital Association is adopting the concept that the hospital should be the purveyor of all health services in the community, and that all who render service, including medical service and including physicians, should be salaried employees.

Until they were stopped by the Insurance Commissioner, a group of hospitals in New York forced the medical staff to turn over to administrators the fees for services rendered in industrial cases in their institutions.

In some areas of our country it is becoming more and more prevalent for hospital administrators to attempt to direct the treatment given to patients, including the ordering of special examinations in order to increase hospital income.

The board of trustees of a certain hospital in the State of California recently passed a regulation forbidding the medical staff to meet for even a social gathering unless the administrator was present.

One hospital in one of our prominent states passed and attempted to enforce a regulation by the board of trustees requiring that the medical staff turn over to the hospital from 10 to 15 per cent of money earned in private practice within that institution. Another hospital in the same state tried to enforce a rule which would require physicians to purchase staff appointments at the rate of $500 each.

One voluntary private nonprofit hospital in the State of Wisconsin is reported to be currently employing department heads at a reputed salary of $10,000 each, and is reported also to be arranging to expand the idea.

There are currently two bills which have been introduced into the current session of the Wisconsin Legislature that, if enacted into law, would allow any corporation to practice medicine in the State of Wisconsin, would allow Wisconsin hospitals to employ any physician they so desire, would allow each hospital to charge for the services of the physician, and split the fee with him, and finally would prohibit the Wisconsin State Medical Society or any county medical society from the sale of benefits for hospital services, even though such is clearly and legally allowed under the Medical Society Enabling Act.

One of these bills is 129–A., which is sponsored by the Wisconsin Hospital Association, and the other bill is 485–A., sponsored by Blue Cross of Wisconsin. We have said for many years, "No, it can't happen here!"

Freedom of Medicine

The issue, members of the House of Delegates of the State Medical Society of Wisconsin, members of the State Medical Society of Wisconsin and members of the Wisconsin Hospital Association, is clear, crystal clear, concise and simple.

It amounts to the same as stated in the conclusions of the report, recently released by the Insurance Commissioner of the State of Wisconsin, which I hope you have read, on its study of prepaid medical-surgical care and hospital insurance plans in Wisconsin, namely: who is going to control the practice of medicine in Wisconsin—the hospitals or the doctors? And to expand on this a bit, who, then, is going to control the practice of medicine in the United States—the government, labor, industry, hospitals, or doctors?

I am going to read to you a letter written to the Board of Trustees by a chief of staff when that staff learned that the Board of Trustees was favoring the passage of Bill 129–A. Gentlemen, I think this letter will go down in the archives of the State Medical Society as one of the finest penned documents, involving the philosophy of the freedom of the private practice of medicine, which we have ever had from a doctor.

March 17, 1959

Board of Trustees
Waukesha Memorial Hospital
725 American Avenue
Waukesha, Wisconsin

Dear Sirs:

The recent action of the hospital Board of Trustees expressing approval of Bill 129–A. constitutes the occasion for this letter. I should like to take this opportunity to briefly develop the arguments against and, I feel, the inherent dangers in this bill.

Originally the relationship between the physician and his patient was an uncomplicated one. His tools were simple ones: the scalpel to lance the abscess, the dressing to cover the incision.

Gradually, as medicine advanced, the tools inevitably became more complex. It became obvious that the more seriously ill patients could be better cared

for in a building staffed with nurses. These buildings or hospitals have become, as you well know, multi-million dollar physical plants. However, the hospital, regardless of its size or monetary worth, remains a tool that the physician uses in the care of his patient. This is the very reason for the hospital's existence.

The people of the community build and maintain hospitals so that their physicians may render them expert medical care with whatever tools are necessary. Strangely, we have somehow lost our perspective. We have forgotten that, although an x-ray unit may have cost hundreds of thousands of dollars, the film it produces is meaningless unless it is interpreted. We have arrived at a point where the hammer wishes to control the carpenter. The machine has petitioned to hire the mechanic.

The hospital's administrative staffs have advanced the argument that they have a duty to the public to maintain high standards of medical care. This stand is not tenable. The patient has nothing to fear from physicians engaged in the private practice of medicine in our free competitive society.

Admittedly there are abuses in medicine, but they are surely minimized by the methods by which physicians have traditionally policed themselves. Who, after all, is capable of judging standards of medical care but physicians themselves? Hospital administrators surely are not qualified to evaluate the degree of excellence of a physician's work.

It is true that hospitals hire nurses. Once again, this has simply become a practice as a matter of expediency. It is convenient for hospitals to collect fees from the patients and in turn to apportion a certain amount of this money to the nurses in the form of salaries. In every other respect the nurse is an extension of the physician. She cannot nurse the patient without the explicit direction of the physician. Only the physician is thoroughly familiar with the patient's needs. Indeed, he has made the diagnosis. Logically, only the physician is capable of judging the adequacy of nursing care and, in turn, of maintaining high standards of this care.

It would seem that the patient has most to fear from those who have interjected themselves between him and his physician. The passage of Bill 129–A. would enable hospitals to hire a full staff of physicians. The fact that many pathologists and radiologists now receive their payment for service from hospitals does not make it right. Generally they are neither happy nor satisfied with this arrangement.

Who is to control the hospital administrator? How can a physician be objectively critical of hospital standards of care, when he receives his salary from the hospital? What defense has the patient against the hospital? He cannot sue an x-ray table. What is to prevent the hospital from profiteering on the skill and talents of the physicians? How can the patient judge the fairness of his bill without knowing what portion of his fee is to represent payment to the physician? What happens to his freedom of choice of physician?

It is sheer naivete to assume that this bill merely represents a way to provide simpler bookkeeping for hospital administrative staffs. It is rather part of an intense struggle for control of medicine. We physicians are almost unanimously opposed to this bill. It is shattering to learn that you cannot understand us. We ask only to be free.

Yours very truly,
s/T. H. McDonell, M.D.
267 West Main Street
Waukesha, Wisconsin

Now, historically, beginning in the early days of the New Deal, the Federal Government exemplified by one Oscar Ewing, attempted to nationalize and socialize medicine in the United States. A deliberate and well-organized campaign of vilification was begun in an effort to belittle the medical profession in the eyes of the public. Our efforts since that time in organized medicine have largely followed plans of apology and appeasement. Such plans have not worked for medicine any better than similar plans have worked for the United States in world affairs.

The medical profession has behaved like a flock of stupid chickens under the shadow of the wing of the hawk. As individual doctors we have scurried for the nearest cover, or crouched in trembling terror, with little thought of defense and less care for the welfare of our fellows.

Take the Offensive

The time for apologies and defense has passed. We must take the offensive. We must use our minds and our hearts and our hands to determine what is best for those we serve —our patients—and what is best for the medical profession, and then follow that prescribed course with due respect but without regard for the inevitable obstacles which we will encounter.

Our social structure, unfortunately, is largely controlled by tightly organized groups; and I submit to you a hypothesis which is nothing new—that only an organized group can survive in our present society.

In the eyes of the public I believe that we, as doctors, are classified as a union. We have to bear the excoriation and the censure which is often heaped upon unions, but we have not had the advantages which come from union organization.

I do not suggest that now, or ever in the future, we refuse to give our best professional services to all of the ill who need us, regard-

less of their ability to pay; but I do suggest that we must use the power of this organization of ours in Wisconsin, as well as other similar organizations in other states, to control the social and economic circumstances under which our medical services are rendered when a third party interposes itself between physician and patient. Such is in the best interests of the patient and in the best interests of medicine.

Many of you who are of my generation, I believe, will draw back in horror from this concept which will seem to you to be the prostitution of all that is ideal in medicine. I do not believe there is any other way, and I am not alone when I say this.

Those of you who represent a younger generation may resist this idea because you will see in it factors which may disturb your present conditions of practice. To you who are of a younger era and of a younger age, I say that you must choose between submitting to a considerable degree of internal discipline or else find yourselves in the future forever displaced to the level of the artisan. To all of you, I say that if you have a better plan or procedure, your profession has never needed the fruits of your hearts and brains and hands more than at this moment, and I call for volunteers.

Medicine must capitalize on the one privilege that is conceded by the courts and which is thoroughly incorporated in our legal structure, namely: the right to use organizational membership to control the conditions of gainful employment.

I propose to you tonight that the Medical Society of the State of Wisconsin create a permanent commission of five of its most level-headed, most astute, most dedicated, most able and, what is more important of all, most courageous men whom we can muster to undertake the continuing task of planning an immediate and a long-range defensive and offensive program designed to preserve the private practice of medicine in the State of Wisconsin.

I propose to the Hospital Association of the State of Wisconsin the thesis that the control and responsibility of the practice of medicine is rightfully in the hands of the medical profession, and likewise that the control and responsibility of hospital service lies within the province of hospital administrators and the boards of trustees.

To both the State Medical Society and the Wisconsin Hospital Association, I say that instead of disagreeing and bickering we each should stay in our own spheres of activity and influence, but unite our efforts to provide the only thing for which we exist, that of better care for those who need us.

I also say to both groups that there are sinister forces outside the field of hospital service and outside the medical profession stealthily waiting on the sidelines, attempting to drive between us wedges which will weaken both. When that weakness is sufficiently advantageous, those forces will surely and swiftly move in for the kill, and both medicine and hospitals will find themselves enmeshed in irreversible, rigid regimentation from which there can be no retreat. May God prevent that day.

The task for both of us will not be easy, but nothing worthwhile is ever achieved through ease. We must forget the Marxist theory that the dignity and the freedom to perform our tasks and to serve our patients in the best way we can see fit is something which we should be ashamed of. As Benjamin Franklin has put it, and put it so well, "They that can give up essential liberty to obtain a little temporary safety, deserve neither liberty nor safety."

Conclusions

Now, what are the conclusions? They are clear, pointed, unmistakable and inevitable.

First, we must recognize that our economic and social order now is largely controlled by highly organized pressure groups, and in this social order it is only through such groups that an individual can ever hope to maintain his dignity and his integrity. This situation is unfortunate, but it cannot be changed and it must be accepted.

Second, as we stand idly by, the rights and privileges of medicine and our immunities are being bargained away by the representatives of labor, industry, government, some insurance companies, and some hospitals.

Third, the Wisconsin State Medical Society must realize and recognize the fact that we are engaged in a power struggle to determine who will eventually control the practice of medicine in Wisconsin, doctors or hospitals. Medicine must acknowledge the gravity of this situation, and medicine must assume the prerogative of creating its own offensive program.

Fourth, the Wisconsin Hospital Association and the Wisconsin State Medical Society must look beyond the present, and see that in the future, if this power struggle continues, both will become weakened and fall prey to other more powerful regulatory forces.

Fifth, the corollary of the above, both doctors and hospitals, must unite in their efforts to provide the best possible care for the needy and the ill of the State of Wisconsin at costs within their reach, and each must stay within its own traditional sphere of influence and activity.

Medicine in Wisconsin, I am convinced, will not fail, because I am likewise convinced that medicine in Wisconsin is right. We must come through with a blueprint for the solution in a manner characteristic of a very well-known Latin motto, "Inveniemus viem aut faciemus"—"We shall find a way or make one."

———

59 Racine Street.

PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I Know About It,
Wis. M. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

Reprints: An order slip for reprints with a table covering cost will be sent with the galley proof to each contributor.

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Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

A Series of Articles on . . .
STAPHYLOCOCCAL INFECTIONS

Report of the Wisconsin Commission for the Improvement of Patient Care

REPRESENTATIVES FROM more than a dozen professional health organizations in the state of Wisconsin met recently as a group, called the Wisconsin Commission for the Improvement of Patient Care, to spearhead a statewide campaign for the control and prevention of staphylococcal infections which have increased significantly throughout the country. While various groups have been conducting individual campaigns, there has been no statewide program to correlate the efforts of these various groups into one massive strike against "staph" infections.

The meeting, held February 4, 1959, at Milwaukee, was conducted by Dr. A. H. Heidner, West Bend, chairman of the Commission and a representative of the State Medical Society. Because of their personal experience and their participation in a regional conference sponsored by the United States Public Health Service, three persons were invited to the meeting to discuss the possibility of the Commission setting up a committee to start an organized statewide campaign to control and prevent staphylococcal infections in Wisconsin. They were: Miss Helen Callon, Madison, Wisconsin State Board of Health; Dr. Kenneth J. Winters, Milwaukee, pediatrician; and Dr. Harold M. Coon, Milwaukee, Director, Milwaukee County General Hospital.

Also attending the meeting in addition to the above were: Adele Stahl, Director, State Department of Nurses, Madison; Ruth Coe, State Department of Vocational and Adult Education, Madison; Richard G. Henry, Wisconsin Pharmaceutical Association, Madison; Gertrude Gloeckler, Wisconsin Conference of Catholic Hospitals, Milwaukee; Keith A. Hinsman, State Medical Society, Madison; Linda Nickel, State Nurses Association, Milwaukee; Mary Claire Hogan, Wisconsin League for Nursing, Milwaukee; Dr. W. B. Hildebrand, President, State Medical Society, Menasha; Martha E. Koch, Association of Licensed Practical Nurses, Milwaukee; Irene Hugunin, Wisconsin League for Nursing, Milwaukee; James J. Morton, Wisconsin Hospital Association, Milwaukee; Anita H. Spera, Wisconsin Association of Licensed Practical Nurses, Kenosha; Mr. and Mrs. Govert J. Vercouteren, Wisconsin Association of Nursing Homes, Sheboygan; and Dr. C. W. Wilcox, State Dental Society, Milwaukee.

At the meeting the foundation was laid for a revitalized committee with representatives from all the major health groups of the state, and having as its chief objective better patient care with particular emphasis on the prevention and treatment of staphylococcal infections. The following are excerpts from the discussion.

Discussion

Chairman Heidner: Three important functions of this committee are: 1. Carry knowledge gained here back to the various groups we represent. 2. Influence legislation bearing on patient care. 3. Help solve the problem of staphylococcal infections.

Miss Helen Callon: The problem is worldwide. In November, 1958, the United States Public Health Service sponsored a meeting in Chicago attended by health personnel from five states in this area. Wisconsin had five representatives.

No formal study has been made of the incidence of these infections in the hospitals of this state. They must be wide-spread, if attendance at the Madison staphylococcus institute in June, 1958, is an index; since 300 persons came to the meeting from 53 of the 71 counties.

While most of the instances reported to me were in surgical wounds, infections of the newborn are equally as serious. Furthermore, they may be overlooked because often they do not appear until several days after the baby has left the hospital. Public health

nurses are beginning to spot these. It is important for the hospital to be aware of this aspect of the problem.

Dr. H. M. Coon: Concerted action by all the hospitals is needed to set up a program of control. A central agency, such as this Commission, is needed to gather information from all parts of the state and channel it back to the hospitals.

At our hospital most of the instances have been in older patients who have had bone surgery. It is rare on our obstetric and pediatric services.

There perhaps has been too much reliance on antibiotics for the control of infections. We need to return to first principles and review critically our aseptic techniques.

The joint commission of accreditation of hospitals has recommended all hospitals establish infectious disease committees. The committee in our hospital, which we call the sepsis committee, has been very active. Its recommendations have been put into effect. Many hospitals will need help in getting the necessary laboratory studies and may find difficulty in supervising their programs. The State Laboratory and this Commission have a responsibility in supplying these needs.

Dr. K. J. Winters: Each hospital infection committee should review the housekeeping and surgical techniques in its hospital. Methods used in cleaning the floors, the handling of contaminated laundry, and skin infections in hospital personnel all have bearing on the problem.

Miss Callon: Many of our practices need to be revised in conformity with changing conditions. Our hospitals now employ more nonprofessional persons than formerly, not only in the service departments but on the floors, in the wards, and even in surgery.

Our students have not been taught good aseptic techniques because we have not been stressing it enough. An example of laxity is in the matter of wearing uniforms on the street.

Doctor Winters: The same thing holds true for the doctors. In many hospitals, the staff members wear operating room gowns as the uniform for the day and travel all over the hospital in them.

Miss Ruth Coe: Some hospitals do not provide a place for the girls to change from street clothes into a uniform.

Miss Callon: And that points up the fact that this is not something which any one group can do much about. It takes uniform planning. Many of the hospitals want a state agency to give them consultation and help in forming the committees and in giving them authoritative support. It is surprising how in certain communities there are internal rivalries and frictions that prevent the effective functioning of the sort of program we are talking about. These hospitals need somebody from the outside to come in and help them.

Doctor Coon: That is right. There is no doubt many hospitals need help.

Miss Callon: Our studies substantiate the impression that hospitals need help. One hospital reported five deaths from staphylococcal infections in 1957. In 1958 there were 27 deaths. Two-thirds of the deaths were in the older age group and the other one-third was in the very young.

Doctor Winters: While the spread of infection among hospital patients and personnel is of great concern, we must not lose sight of the fact that the staphylococcus is common in the streets and that many of the infections in the hospitals are carried in with the patient.

The Wisconsin representation at the November meeting in Chicago recommended that the Wisconsin Commission for the Improvement of Patient Care organize a subcommittee on hospital infections to promote the formation of an infection committee in each hospital. The efforts must be extended not only to the hospital but also to nursing homes, orphanages and children's homes.

Doctor Coon: County medical societies and area hospital councils are well aware of the gravity of the situation. A great deal of care and thought must be given to the type of information that is put out for the public. We must think of the impact this publicity has on the public.

I would like to emphasize also that there are methods of hospital housekeeping that can be improved.

Dr. W. B. Hildebrand: Granted the problem exists; how extensive is it? Are there any statistics on its prevalence in Wisconsin? We have nothing I know of from the medical angle which will place the problem numerically.

Doctor Coon: I do not know where you can get definite figures.

Doctor Winters: The incidence among infants is not recognized statistically because the vast majority occur after the babies go home and unfortunately no one reports these. The hospital committee does not find out about them unless by chance one of the members gets the information by word of mouth.

Doctor Coon: It has been suggested a call system be used and that mothers be called at the 5th day and the 10th day after leaving the hospital. There have been some unfavorable reactions, however, to this practice.

Doctor Hildebrand: Control has to be broadened to take in these as well as those patients seen in the doctors' offices with various types of staphylococcal infections. Many of these patients never enter hospitals, yet they are often important links in the chain of transmission. How this is to be accomplished is quite another matter.

Miss Callon: This is one of the reasons why we recognize that the committee should have a broader scope than the one taken by those of us who attended the November, 1958 meeting in Chicago.

Doctor Winters: The problem has been focused in the hospital because there it can reach epidemic proportions.

Chairman Heidner: Many of us took our training in the era of the Lane technique in bone work. We perhaps need a return to this type of precaution.

Doctor Coon: There are in this state some bone surgeons who still use the Lane technique.

Chairman Heidner: I bet they do not have many staph. infections.

Doctor Coon: I am concerned about the publicity in some of our current magazines. Much of the reporting is put to the public in a defamatory manner. This Commission should foster the right kind of education of the public. The hospital visitor problem plagues all of us.

What we are trying to do right now is to bring back hand washing in the hospitals.

Miss Callon: The hospital architects also need education. Adequate handwashing facilities are not always included. I know of one 20-bed unit with only one handwashing facility, and that in a new modern hospital.

Doctor Winters: The faulty location of the air intake for air conditioning can be responsible for spread of infections. One large hospital where they were having infections had its intake duct near the windows of the laundry. All the lint and dust was being sucked right in and all the infected linen from the patients in isolation was mixed with others and the air from the laundry went right up to the operating rooms. The operating room technique was good but the patients became infected. A committee reviewing the problem in a hospital will trace the route of soiled linen from its source, to the laundry, and back to the storage closets and can discover the areas of contamination.

Chairman Heidner: As for example, on the passenger elevators.

Miss Adele Stahl: I propose the group who attended the Chicago meeting outline a program for this committee to carry out. I suggest the program include all hospital people, the medical personnel, registered nurses, practical nurses, home nursing operators and all who have anything to do with the care of the sick. I understand the county medical societies have a committee on this problem.

Doctor Hildebrand: We do. During the latter part of 1958 the subject was emphasized in certain teaching programs. The maternal mortality institute on January 29th devoted considerable attention to it. Our emphasis has been more on the scientific aspects, the pathologic and bacteriologic factors involved rather than actual techniques in prevention. Those aspects are in the realm of nursing care and hospital administration.

Miss Irene Hugunin: The value of making staphylococcal infections reportable should be looked into.

Doctor Coon: This would raise problems because of the great variety of staphylococcus organisms. Hospitals with tissue committees can establish the diagnosis.

Miss Callon: Of course, that is important, and can be handled in a large hospital but we have something like 100 small hospitals which do not have tissue committees.

Doctor Coon: It is the lack of adequate laboratory facilities more than the tissue committee that is the limiting factor.

Dr. C. W. Wilcox: From the dentists' viewpoint we are well aware that staphylococcal infections do occur in the oral cavity and that aseptic techniques are of paramount importance. Antibiotics cannot be relied upon to give full protection against complicating infections.

Chairman Heidner: The great value of this committee is that it is a joint body. Recommendations coming from it will be free from the criticism of pointing out any one group as more lax than another.

Mr. Grovert J. Vercouteren: I represent the Wisconsin Nursing Home Association. I was very happy to hear the discussion this afternoon. I do not have any particular knowledge that nursing homes have a staphylococcal infection problem, but I am sure that some of them do and I am sure that the Wisconsin Nursing Home Association in its entirety would be much interested in keeping the infections out of nursing homes as much as possible.

Miss Linda Nickel: The Wisconsin State Nurses' Association has started action relative to developing a program for the prevention and control of staphylococcal infections. Each district has been urged to begin immediate action and to report back to the state organization on its activities. The second district already has a meeting planned with the pathologists who will meet with the nurses.

Chairman Heidner: Does anyone in the Commission have any suggestions as to reorganization so that we can carry on the program?

Doctor Hildebrand: I move the chairman appoint a subcommittee to meet as often as necessary to draw up a set of recommendations designed to aid in the overall control of infections which have become a problem not only in our hospitals but also in our various local communities (a vote was taken and the motion was passed).

WHEN THE RECOMMENDATIONS of the American Academy of Pediatrics on techniques of care of the newborn were carried out, infections were almost eliminated from newborn nurseries. It was only with the advent of antibiotics, when it was believed that they could be a substitute for good nursery techniques, that difficulties have been encountered. It has been only since the relaxations of these rules that we have had these epidemics. If hospitals will completely return to these regulations as recommended by the Academy 20 years ago, very little trouble will be encountered. In Chicago where the Health Department insists that these nursery regulations be enforced, we have had no more trouble in recent years than before.— Heyworth N. Sanford, M.D., Chicago, in an article to be published later in the *Wisconsin Medical Journal.*

THE OBSERVATIONS OF Dr. John Fairchild reported in the November, 1958, issue of *Journal of Pediatrics* indicate that a high percentage of the newborn are contaminated with Staphylococcus but that "their nursery was under sterile control and no infections developed. This shows that if good techniques of care are used there will ordinarily be no difficulty."—Heyworth N. Sanford, M.D., Chicago, in an article to be published later in the *Wisconsin Medical Journal.*

The Epidemiology of Staphylococcal Infections*

By THOMAS E. SHAFFER, M. D.**

Columbus, Ohio

WHILE STAPHYLOCOCCAL infections have become a serious problem in all branches of medicine because of cross-infections in hospitals, they have been especially vexing for pediatricians and obstetricians. The most impressive evidences of staphylococcal disease in recent years have been observed among very young infants and post partum women. The commonplace and seemingly insignificant lesions of impetigo in the newborn infant, familiar to practically every physician, have been the forerunner of a number of disastrous epidemics of staphylococcal infections in maternity services in the past few years.

In all such epidemics in various parts of the world a pustular skin lesion has been the most common manifestation of the infection among infants. This lesion is a friable vesicle partially filled with purulent liquid and usually measuring 0.5 to 1.5 cm. in diameter. The lesions appeared most frequently in the folds of the axilla, neck, and buttocks but may be seen on any part of the body. Fluid from the vesicles is shown to contain polymorphonuclear leukocytes on direct smear and as a rule coagulase-positive *Staphylococcus aureus* is grown on culture. The only condition likely to be confused with staphylococcal pyoderma in infants is *erythema toxicum*. This latter condition is common among newborns and consists of numerous small red papules resembling hives upon which there is often seen a small vesicle containing clear fluid. If there is confusion between erythema toxicum and staphylococcal pyoderma a direct smear usually clarifies the problem because the cells from erythema toxicum are predominately eosinophils.

Among infants during an epidemic of staphylococcal infections a significant number of serious infections such as breast abscesses, pneumonia, empyema, cellulitis, septicemia, and osteomyelitis have been noted. The frequent development of breast abscesses among the infants has been a remarkable occurrence. Approximately 25 per cent of the infants born during an epidemic in a maternity unit sooner or later developed evidences of infection acquired while in the hospital and many more carry the causative organism without symptoms of infection. Breast abscesses have occurred in approximately 25 per cent of the mothers who nursed their infants during an epidemic.

Since 1954 our group at the Ohio State University has examined in our laboratory cultures obtained from lesions in more than 70 epidemics of staphylococcal disease in nurseries in this country, Australia, England, Hawaii, Denmark, Germany, and Canada. Until about five years ago precise identification of staphylococci obtained from lesions was impossible because of the difficulty in differentiating various strains on the basis of biochemical characteristics (color, hemolysin production, coagulase production, and other virulence factors). At the present time, however, bacteriophage typing has been developed as a practical means for exact characterization of single strains of *Staphylococcus aureus*. By this procedure, augmented by determination of patterns of sensitivity to various antibiotics, strains of *S. aureus* responsible for practically all of the widely separated outbreaks in maternity services throughout the world for the past eight years have been shown to be essentially identical. We have come to believe this strain is particularly virulent for the tissues of newborns and mammary glands of post partum women. One might consider the situation similar to the specificity of group A type 12 beta hemolytic streptococcus in causing acute glomerulonephritis, and the tissue specificity of various viruses.

The "epidemic strain" of *S. aureus* from epidemics in maternity units in recent years is consistently lysed by phages 80 and 81 and usually by 42B, 47C, 44A, and 52. This strain has been specified as 80/81 by the Interna-

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tional Reference Center, but the same strain has also been designated 42B/47C/44A/52/80/81, or 52/42B/80/81, or 52/42B/81, etc. when phage distributed in the United States were used for typing. In some laboratories phage 42B, 47C, and 44A have mutated to broader specificity and are no longer useful in characterizing the epidemic strain. During an epidemic this strain of *S. aureus* has been obtained from pustular lesions of the skin, omphalitis, conjunctivitis, mastitis, parotitis, pneumonia, empyema and septicemia. The organism is also found commonly in cultures from the nasal mucosa and skin of individuals who have manifest infections elsewhere on the body (symptomatic carriers) as well as from those who are not ill (asymptomatic carriers). These latter as a rule can be shown to have become nasal carriers through contacts with infected individuals or other carriers. Some asymptomatic carriers harbor the organism for only a brief time and might be termed "transient carriers" while others continue to carry the organism on their nasal mucosa or skin for many weeks or months and we have termed them "persistent carriers".

Nasal or skin colonization of infants may take place in the nursery during the first few days of life, while signs and symptoms of staphylococcal infections may not occur until weeks later. This long, latent period during which asymptomatic colonization exists without manifest disease has grave public health implications because an antimicrobial-resistant, pathogenic strain of *Staphylococcus aureus* may in this manner be disseminated from the hospital to the home and community. It is reasonable for physicians and nurses to assume that purulent lesions occurring in an infant aged less than three months or in members of a newborn's family are almost certainly due to a strain of antimicrobial-resistant staphylococcus, presumably acquired in the hospital. Such family infections should be considered to be potentially of great pathogenicity and presumably due to organisms resistant to penicillin, the tetracyclines, and streptomycin.

Pyogenic infections in a family in which there is a young infant point, furthermore, to the probable existence of a focus of infection and potentially epidemic conditions in the nursery where the infant was born. We firmly believe that it should be mandatory for purulent lesions of infants less than three months of age and those of post partum mothers be reportable diseases so that epidemiologic investigations may be made in the hospital where delivery occurred. Without such a policy, hospital administrators and heads of obstetric and pediatric services might not be alerted to nursery-acquired colonization and infections in time to control an epidemic.

As a means of surveillance since 1954 we have employed a questionnaire, given to mothers upon their departure from the maternity unit to be returned after they have been home four weeks. Among the questions are some designed to indicate whether the infant or mother has developed purulent infections. Patients have been surprisingly cooperative about returning the questionnaires. With the help of public health authorities and practicing physicians in the community, follow-up of any reply indicating infection of infants or mothers has been carried out. Without a program of follow-up employing questionnaires or telephone calls it would be impossible to detect epidemic infections in maternity units until the infection has become widespread throughout the community.

It is interesting to speculate whether the clinical manifestations of staphylococcal infections in infants are related to basic differences in susceptibility in this age period. There are a few studies in this field but most of them indicate that those maternal antibodies against staphylococci which can be measured in the mother's serum do pass the placenta and appear in the newborn infant. After several weeks these antibodies in the infant's serum appear to diminish, to reappear slowly in ensuing years of childhood. While it is doubtful whether the measurable antibodies (antistaphylolysin, antihemolysin, anticapsular agglutinins) are responsible for preventing invasion by organisms harbored in the nose, the latent period between colonization and clinical infection mentioned above does have a time relationship to the disappearance of passively transferred antibodies. Low concentration of coagulase reacting factors in newborn infants and young children has been reported by Rammelkamp and Lebovitz. These investigators postulated that this might have an effect on the localization of staphylococcal infections. Although it is true that staphylococcal septicemia and widespread pneumonia are more common in infancy and childhood when the coagulase re-

acting factors are reported to be at low levels, localized abscesses nevertheless do occur in infants.

In epidemics in newborn nurseries the strain of staphylococcus isolated from lesions has usually been identified in nasal cultures of some of the personnel working in the nursery as well as from the infant patients. Healthy babies acquire the strains harbored by personnel who have prolonged contact with them. Even though mothers come into intimate contact with their babies in the hospital, they are practically never the immediate source of staphylococci acquired by their infants. The reverse is not true, however, for we have often found that infants with clinical staphylococcal infections are responsible for colonizing the skin and nasal mucosa of their mothers within a few weeks or even days.

Our studies of the manner in which newborn infants acquire *Staphylococcus aureus* have shown that there are marked differences in the capabilities of various strains to colonize infants. Of 54 different phage strains of *S. aureus* isolated from more than 1,200 newborn infants, five strains accounted for 75 per cent of the colonization of infants and one strain alone represented 30 per cent of coagulase positive staphylococci isolated from the infants. As a rule only one strain of *S. aureus* predominates in a given nursery at any one time. This situation presumably holds true for hospital wards in general as has been noted by other observers. When the adult carrier of the predominating strain, almost invariably a nurse, is transferred to another nursery, our experience has been that the strain has disappeared only to become prominent in the nursery where she was reassigned. A different strain appears and predominates in the nursery which the carrier has left. The role of the asymptomatic healthy adult carrier of staphylococci in initiating and prolonging epidemics of infections apparently depends both on the carrier's personal conduct (coughing, sneezing, laughing, touching nose and face, use of cloth handkerchief) and on the potentiality of the organism she carries to colonize infants. When the carrier is a "good disseminator" and the organism is a "good colonizer", almost all infants acquire the organism in a short time and an epidemic develops if the strain is virulent. Occasionally a strain is such a good colonizer or conditions in nursery are such that a strain can persist in the nursery by airborne passage after the adult carrier is removed. It is in this manner that strain 80/81 has been noted by several observers to continue colonizing infants in the nursery.

Good hygenic practices in the nursery (hand washing, control of dust, the manner in which clothing and surgical dressings are handled and the deportment of personnel) are extremely significant to the amount of dissemination of staphylococci from carrier to patient and from infected patients to other patients and personnel. We have demonstrated that use of bactericidal liquid detergent to cleanse the skin of newborn infants reduces the dispersal of staphylococci into the environment. Studies of a nursery during periods when vernix caseosa was not removed from the skin by bathing showed *S. aureus* could be recovered from mattresses and the crib railings, from articles commonly handled by the nurses, and from surfaces on which lint from bedding and clothing collected. During periods when hexachlorophene bathing was practiced, fewer organisms were isolated from the same areas and at the same time the colonization of the infant's skin and nasal mucosa was significantly reduced.

It appears that when a strain of *S. aureus* has become established in a nursery where hexachlorophene bathing is not practiced, inhalation of airborne vernix caseosa or blanket lint contaminated with staphylococci results in an increased rate of nasal and skin colonization.

Most adults who become asymptomatic carriers through contact with patients harbor that strain of Staphylococcus for only a short time. When contact with open infections is discontinued, they are no longer carriers of that strain. However, some individuals become permanent carriers and the disposition and treatment of such persons is one of the most disturbing problems in the control of staphylococcal infections in hospitals today. The advantage of detecting and controlling asymptomatic nasal carriers has been demonstrated by our experience at The University Hospital in Columbus in recent months. We try to detect the carriers of known pathogenic strains of *S. aureus* by nasopharyngeal cultures before duties in the nursery are assumed, and by periodic monthly culture surveys of all maternity service personnel. Carriers of recognized pathogenic strains are denied entry to the

nursery. Under this program, in a nine-month period no clinical infections among infants or mothers had been noted. The detection of carriers and the control of their duty assignments is far easier to accomplish than is treatment to clear up the carrier state. Treatment except by preventing contact with infected individuals has not been satisfactory.

Recommendations for the control of staphylococcal hospital infections when epidemic conditions prevail would include the following measures:

(1) Identify the organism causing the lesions and establish the common identity of strains recovered from lesions in a number of patients.

(2) Identify carriers of the lesion-producing strain among personnel by culturing their purulent lesions if present and obtaining nasopharyngeal cultures from all personnel caring for patients. Remove adult carriers from contact with the patients.

(3) Separate all infected cases and all patients who are asymptomatic nasal carriers from new admissions.

(4) Appraise hospital practices to detect errors in technique which would encourage dispersion of pathogenic organisms.

(5) Open an area for admission of new patients and staff with personnel known not to be carriers of the epidemic strain of staphylococci.

(6) During the time when carriers are being identified and noncarriers are being sought for the "clean nursery", it might be necessary to protect infants from the *moment of birth* by antimicrobial therapy appropriate for the strain causing the epidemic. Such a preventive measure should be used only for the brief time when carriers are being identified and removed. The drug should be given to every infant coming into the nursery and in *therapeutic dosage;* treatment should not be used until after all carriers of *S. aureus* resistant to the antibiotic in use have been identified and removed from the nursery. Under such a policy it is possible to prevent nasal and skin colonization of newborn infants by the pathogenic strain and with the enumerated precautions; colonization by staphylococci resistant to the antibiotic in use can also be prevented.

STAPHYLOCOCCIC FOOD POISONING is the type of enteric disease responsible for about 75 per cent of all food-borne cases of gastroenteritis reported in this country. The staphylococci are among the commonest of disease-causing bacteria. In general, they cause such common diseases as pneumonia, boils and styes, carbuncles, abscesses, and ear, nose, throat and sinus infections. They invariably seem to be present as secondary invaders in the most frequent of all illnesses, the "common cold." We have already learned of two factors before staphylococcic food poisoning can occur. First, the staphylococci must get into the food and since they do not occur naturally in it, the food must become "contaminated" with them. Second, the contaminating staphylococci must be of the enterotoxin-producing variety. We have no way, as yet, of knowing just which staphylococci can produce this toxin in food. But from these known factors we can recommend the first measures for prevention of staphylococcic food-poisoning: people with colds, skin lesions or infections, etc., should not engage in the preparation of food.—MILTON FEIG, M. D., Director, Section of Preventable Diseases, Wisconsin State Board of Health, in *Health*, January, February, March, 1959.

Staphylococcal Infections in Obstetrical and Surgical Patients*†

By ALFRED L. KENNAN, M. D.**

Madison, Wisconsin

THE CONTINUUM OF obstetric and surgical morbidity and mortality from *Staphylococcus aureus* var. pyogenes has enjoyed a recrudescence since the advent of antibiotic therapy. This has been ascribed to two major changes in hospital routine. First, the transcendent use of these new drugs with resultant selection of those strains which are inherently resistant *e.g.* strains that produce penicillinase which converts penicillin to penicillioic acid which is inactive. Secondly, the lack of meticulous wound care both during and after the surgical procedure. These assertions may seem self evident but in a study of the factors involved in a steadily increasing rate of surgical infection and a concurrent epidemic among the mothers and newborns, they seem most germane.

In studying the factors associated with infection of the breasts, material was obtained from patients and from all the 56 personnel employed on the obstetric floor.

During the study 117 live births occurred. No coagulase positive staphylococci were isolated from vaginal cultures taken from 99 mothers just after delivery. Fifty of the births were attended by an obstetrician who was a carrier; and though a number of these infants became colonized and infected, none had the strain carried by the obstetrician. The bedding of the mothers was never identified as a source of infection for the epidemic strain. Ninety of the mothers were followed in the post partum clinic. In 9, definite evidence of mastitis or breast abscess appeared and in 1 this was bilateral. (Table 1). Purulent material was obtained from the breast in 4 of these mothers. In each case the staphylococci isolated were resistant to penicillin, streptomycin, and tetracycline and were of the phage type noted 52/42B/81. The same strain was recovered from the breast milk in 3 additional mothers. This is the same strain that was producing a concurrent epidemic in the nursery. Because of the daily cultures from mothers and infants it was possible to determine with reasonable accuracy whether the mothers or infants were the chief source of infection. None of the mothers carried this strain on admission. All their infants were found to be colonized with the epidemic strain before it was isolated from any of the mothers, and 8 of the infants had clinical staphylococcal infection before the onset of breast infection in the mothers. All 9 of these mothers breast fed. Of 19 mothers who breast fed infants colonized by a nonepidemic strain and 67 mothers who did not nurse their infants, there were no breast infections even though 34% of these infants were colonized with the strain.

TABLE 1—BREAST INFECTIONS OF MOTHERS

Patient	Type of Breast Infection	Pyoderma of Infant	Staphylococci of Epidemic Strain Isolated			
			From Mother's Breast Milk Before Breast Infection	From Mother's Breast Milk During Breast Infection	From Mother's Breast Lesion	From Infant's Skin, Nose or Throat
J.H.	Mastitis	+	+			+
M. T.	Mastitis	+	+			+
E. T.	Abscess	+	+		+	+
P. M.	Abscess	+		+	+	+
J. W.	Abscess	+		+	+	+
H. W.	Abscess	+		+		+
O. W.	Mastitis	+			+	+
D. J.	Abscesses	+				+
M. P.	Abscess	0*				+

*Inadequate follow-up study of infant.

To investigate the mechanism of infection a culture was taken from the formula bottle before and after feeding in 13 infants. Nine of these had the epidemic strain in their throats and it was recovered from the formula bottle in 7 instances. Of the 4 who had negative throat cultures none of the formulae

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†Material was taken from an extended study of the epidemiologic factors in hospital acquired infections, parts of which have been published in the *New England Journal of Medicine* 257:295, 304. 1957, with the senior author: Donald N. Wysham, M.D.

**From the Department of Obstetrics and Gynecology, University of Wisconsin Medical School.

Table 2—Relation of Clinical Breast Infection of Mothers to the Type of Infant Feeding and to the Colonization of Infants by Staphylococci

Type of Feeding	Infants Colonized by Epidemic Strain of Staphylococci	Infants Colonized by All Other Strains	Infants Not Colonized by Staphylococci	Totals
Breast:				
Infants	23	19	8	50
Mothers with breast infection	9	0	0	9
Formula:				
Infants	34	30	3	67
Mothers with breast infection	0	0	0	0

contained staph. Presumably negative pressure is created within the ducts and sinuses during sucking. When this is released, an inoculum from the infant's throat may be aspirated into the ducts. (Table 2).

In conclusion it was found that 40% of the mothers who nursed infants, colonized and infected by the epidemic strain, in turn developed mastitis or breast abscess. The infants probably acquire the staphylococci in the nursery from other infants and transmit the infection during nursing. Consequently, measures designed to prevent maternal mastitis should not be limited to the care of the mother's nipple but should also extend to the nursery where the virulent organisms are acquired by the infants.

Surgical infection with the Staphylococcus is universally present in hospitals and cannot be entirely eliminated. The population dynamics make the problem appear more grave at certain times than at other times. Strain selection occurs with antibiotics in the fashion previously outlined; and while the epidemiologic studies which follow are of considerable interest, corrective action does not reconstitute the normal group and strain relationships and thereby the normal air content of various staphylococci. When the hospital flora is comprised largely of resistant strains, a steadily increasing incidence of infection will be noted. The problem assumes unusual proportions when contaminated wounds are included. This would seem important for they become infected with staphylococci from the hospital environment.

The epidemiology is multifactorial and those which seem most important will be briefly mentioned.

First, the average age of clientele on a large surgery service has increased some 15 years, and thus they are exposed at a less advantageous age. Much is still unknown about the resistance of a given individual to these organisms.

Secondly, staphylococcal infections are still not considered contagious. On the one hand we stress carrier responsibility and then permit these infections to remain in the open wards. This situation is further exaggerated by the abandonment of surgical principles of asepsis and antisepsis gleaned over many years of bitter experience. Lapses in technique were easily observed during wound dressing, bedside care, and handling of infected material by house staff, registered nurses, and practical nurses alike. The mask, gloved hand, use of instruments to change dressings and washing of hands between cases are details in care that must be performed assiduously. The ambulatory patients assist in this dissemination by sitting on the bed and coming into contact with the bed clothes of the infected patient. (Fig. 1).

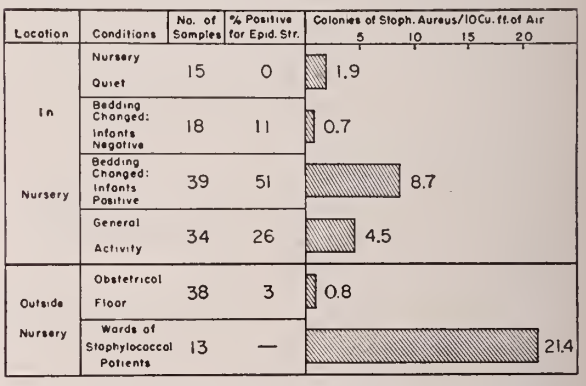

Fig. 1—Air samples taken with a slit air sampler on the obstetric floor and on other floors in wards of adult patients with draining staphylococcal infections. The horizontal bars represent the average numbers of colonies of *Staphylococcus aureus* recovered from these samples. A marked rise in air contamination in the nursery is evident during the changing of bedding of infants colonized by coagulase-positive staphylococci.

Cultures from unlaundered blankets and mattresses were taken from unoccupied beds on the ward. The cultures from laundered blankets were taken in the laundry immediately after drying.

The recommended square area of floor space per bed is 80 square feet. None of the wards examined met this requirement.

Hospital blankets and mattresses were a major repository of staphylococcal organisms for blankets were not laundered between patients and mattresses are not ordinarily cleaned unless they are grossly and visibly

contaminated. (Table 3). Therefore, it was possible for a clean case to enter a bed in which the blankets were heavily contaminated by a previous infected patient who had not grossly soiled the blankets or mattress.

TABLE 3

Unoccupied Beds	No. Cult.	No. with Staph.	% of Total	No. of Colonies on Plates	% of Total Resist. to Penicillin	% of Total Resist. to 2 or More Antibiotics
Blankets	44	18	41	1-100	50	44
Mattresses	43	15	35	1-100	53	60
Laundered Blankets	62	16	26	1- 17	31	31

These bacteria remain virulent for months or years, and a freshly laundered sheet which may be free of bacteria has no protective effect. In the hospital laundry, the dirty linen was sorted in the room which contained the dryers. The air drawn through the dryers could thus replace the staphylococci removed by washing. The temperature of the dryer was not sufficiently high to kill these organisms.

Convergence of the surgical services in the operating area makes this a place where imprudent procedure has widespread effects. Here the litters, covered with blankets from the wards, remain in corridors frequented by physicians and personnel who lounge over them during breaks from a variety of procedures. Exhaust fans in the utility areas reinforce the normal circulation until at operating time an open petri dish containing agar will accumulate some 20 colonies an hour, half of which contained the resistant bacteria. Face masks on carriers become saturated with bacteria which eventually appear on the exterior of the mask and get under way from there. It is now recommended that they be changed every hour on personnel who are carriers of resistant strains. Few organisms have the quality to invade, so established principles of meticulous abdominal preparation, gentle atraumatic techniques, dry wounds, and careful closure reduces devitalized tissue and the nutritional pabulum of sepsis to a minimum.

There is no area in hospital environment where infected personnel can or should be allowed. Finally, the aspersed carrier must be mentioned and there is clear evidence for implication in the occasional epidemic, but the carrier effect on overall wound infection becomes less clear as additional details accumulate. An "a priori" relationship can hardly exist when the patient is wrapped in swarming clothes, delivered to an operating room where the foamites from all the surgical floors congregate and are circulated by an exhaust fan, be operated upon by a carrier, and then delivered to his bed again wrapped in swarming clothes adjacent to an infected patient.

The situation is not nearly so hopeless and simple measures will suffice.

The prophylactic use of antibiotics should be discontinued and used only where the sensitivity is known. Antibiotics should be used in combinations whose effect is different for the expected frequency of double mutation, and first step resistance in a single bacteria is 1×10^{-14}, or 1 in 10 liters of bacteria. Wound infections should be carefully segregated and isolated. Hospital bedding should be laundered using one of the currently available preparations which sterilize during the wash. This adds 4½¢ to the cost of laundering a blanket. "No Hands" dressing technique should be revived. In several hospitals these simple measures have proven adequate to reduce the postoperative wound infections to their normal 2%.

Safe Use of Anesthetics Featured in Film

The Bureau of Mines, Department of the Interior, has completed a new 16 mm., sound-and-color safety picture, "Fire and Explosion Hazards From Flammable Anesthetics." The 30-minute motion picture is available for limited distribution, on free short-term loan, to organizations directly concerned with operating- and delivery-room safety. The film, sponsored by Abbott Laboratories, can be obtained from Graphic Services, Bureau of Mines, Department of Interior, 4800 Forbes Ave., Pittsburgh 13, Pa., for showing to hospital and medical societies, hospital administrators, anesthetists, nurses, safety organizations, and similar groups.

Filmstrips on Major Medical Exhibits Now Available

The second edition of "Exhibits-on-Film" is now available free of charge to all medical colleges and county, state and regional medical societies. Three filmstrips in the newest series include:

"Bone Marrow Patterns in Infancy and Childhood", by Drs. Thomas L. Rider, Paul R. Patterson and Simon Propp of Albany (N. Y.) Medical College and Albany Hospital. This exhibit was presented originally at the 1958 American Academy of Pediatrics Meeting in New York City.

A combined strip featuring "Cancer Cells in the Circulating Blood" and "Hematopoietic Response to Iron Dextran Therapy". The cancer cell exhibit was prepared by Dr. Alvin L. Watne and associates of the University of Illinois College of Medicine and was presented at the 1958 annual convention of the American Medical Convention in San Francisco. The second segment of the filmstrip is based on the exhibit prepared by Drs. Herbert S. Bowman and Rosemarie J. Tursky of Harrisburg (Pa.) Hospital which was presented at the American College of Physicians' 1958 Meeting at Atlantic City, N. J.

The third filmstrip in this series features the work of Dr. Roy F. Goddard and associates of Lovelace Foundation. This project, a review of pediatric bronchopulmonary disorders, is also from the A.M.A. convention.

Running time for each strip is 15–20 minutes.

"Exhibits-on-Film", a Lakeside-sponsored project, may be obtained from Helen Martin, Executive Secretary, "Exhibits-on-Film," Lakeside Laboratories, Inc., 1707 East North, Milwaukee 1, Wisconsin.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service plan.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Occupational Health, A Guide for Medical and Nursing Personnel**—General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
14. **The Income Tax for Wisconsin Physicians**—A brochure, newly revised, containing a review of the state and federal income tax laws as they apply to the physicians of Wisconsin.
15. **The Doctor's Role in Adoptions**—A reprint of three *Wisconsin Medical Journal* articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Antibiotics in Relation to Staphylococcal Infections*

By WALTER S. WOOD, M. D.**

Chicago, Illinois

BEFORE DISCUSSING THE effects of antibiotics upon staphylococci, it would seem proper to consider some of the fundamental characteristics of these ubiquitous bacteria. Staphylococci are highly communicable and infective for man. Although man is especially susceptible, infections may occur in animals, spontaneously and experimentally. These bacteria have a tendency to infect the skin and open wounds, particularly those in which a foreign body exists, including sutures and indwelling intravenous catheters. Infectivity is exaggerated in the newborn, the aged, and the chronically ill. The seriousness of staphylococcal pneumonia in persons with influenza is well recognized. The hazard of staphylococcal infections in patients with diabetes mellitus is no less existent now as compared to the pre-antibiotic era. Such therapeutic devices as radiation therapy, the corticosteroids, and splenectomy have seemingly given some impetus to the problem.

M. pyogenes var. aureus has a multitude of biological characteristics, some of which correlate with its pathogenicity for man. Although not a sine qua non of virulence, most pathogenic strains produce a golden pigment. They produce a wide variety of enzymes, including phosphatases, hemolysins, fibrinolysin, hyaluronidase, leukocidins, and coagulase. Certain strains produce an enterotoxin and several exotoxins have been demonstrated. Coagulase is helpful in the identification of the more virulent strains. It permits staphylococci to clot human plasma and is consumed in this process. Coagulase may inhibit phagocytosis and in addition apparently protects staphylococci from a normal serum staphylococcal inhibiting factor. The interaction of coagulase and inhibiting factor initiates a fibrin barrier which may be significant in abscess formation. The tendency of adults to form abscesses and the tendency of infants as well as adults with lessened resistance to develop bacteremia and more widespread disease has been attributed in part to the presence or absence of the serum inhibiting factor.

Phagocytosis occurs as an essential part of the host's defense mechanism in response to invasion by staphylococci. Usually phagocytosis assists in eradication of the organisms. Depending upon the characteristics of the invading Staphylococcus and the host's natural resistance, it is possible that phagocytosis may permit lengthened survival of the bacteria, similar to the observed phenomenon in brucellosis and tuberculosis. Phagocytosis has been suggested as perhaps contributing to drug resistance and chronicity in staphylococcal disease.

Spontaneous staphylococcal infection produces little potent immunity in man although circulating antibodies may be irregularly demonstrated. Immune serum does enhance phagocytosis but has little bactericidal action. Rabbits can be protected from bacteremia by the injection of heat killed organisms, and toxoid administered experimentally to laboratory animals protects against the acute lethal effects of toxin. Similarly, antitoxin has a demonstrable protective effect experimentally. Although vaccines and antitoxin currently play only a minor role in the treatment of staphylococcal infections in man, this remains a challenging and likely a productive approach.

The introduction of antibiotics has significantly altered the natural history of staphylococcal disease. Although acute osteomyelitis and the carbuncle have seemingly almost disappeared from the hospital emergency room, the incidence of terminal and infant staphylococcal pneumonia, breast abscess, empyema, and secondary bacteremia seem to be more prevalent. The actual incidence of staphylococcal infections is not well known because

*Presented at Symposium on Prevention and Control of Staphylococcal Infections June 19, 1958, at the University of Wisconsin Medical School, Madison.

**From Hoektoen Institute for Medical Research, Department of Medicine, University of Illinois College of Medicine.

of inadequacies in reporting. Antibiotics have apparently reduced the incidence of primary staphylococcal disease as it appears in the community. The major increases noted are those infections which appear for the most part secondarily, particularly in hospitals. The overall mortality from staphylococcal disease has been only partially abated by antibiotics. There has been a striking diminution in the mortality of the closed primary infection of community origin whereas the mortality in hospitalized patients, particularly those with diminished natural resistance, has apparently increased in spite of or perhaps partially due to antibiotics.

The staphylococci are not only omnipresent but also are markedly heterogeneous and this is of particular relevance with respect to their varied and complicated patterns of resistance to antibiotics. Some strains are predominately and naturally resistant to one or more antibiotics. Other strains are predominately sensitive but are composed in part of a few resistant clones originally arising by mutation. Mutation can occur by exposure to an antibiotic, although this is not the major apparent mechanism in resistant infections. Hence, the antibiotic resistance of staphylococci as it occurs in patients may be attributed to the selection by antibiotic-host interactions of pre-existing resistant clones. Generally, the rate at which resistance develops to an antibiotic is determined by the proportion of resistant clones in the total strain population and the degree of this resistance. If the difference between the sensitive and resistant clones is small, resistance to the antibiotic tends to be gradual whereas resistance may be stepwise and rapid if the difference in susceptibility is great.

Acquisition of resistance is also determined in part by the spectrum of the antibiotic agent or combination of drugs used and how severely the natural flora of the host is disturbed. Both endogenous and exogenous resistant implants are more likely to ensue when the competing organisms are removed. In this respect, the ideal anti-staphylococcal agent would be one with narrow and specific activity.

There is little tendency for resistance to develop in the same staphylococcal strain while the patient is receiving antibiotic therapy. Hence, it would be unusual for a closed staphylococcal infection resulting from a sensitive nonpenicillinase-producing strain to become resistant to penicillin during the period of its administration. Penicillin is the most effective bactericidal agent available for use in those infections attributed to sensitive strains. Penicillin remains a most effective antibiotic in the treatment of staphylococcal infections originating from the community as distinct from its relative ineffectiveness in many hospital-acquired infections. Between 50 to 80 per cent of community strains are sensitive to penicillin whereas approximately 85 per cent of hospital strains are resistant to this antibiotic. Patients acquire resistant staphylococci quite rapidly upon hospitalization and gradually lose the resistant strains upon returning to the community. The latter may be transferred to family contacts, and in addition, sensitive organisms from family contacts replace the resistant strains of the patient. The hazardous effect of the contaminated newborn returning to the home and serving as a source of resistant infection to the rest of the family is a well-recognized phenomenon.

Staphylococci develop resistance to erythromycin and streptomycin more rapidly than to penicillin and the tetracyclines, However, the use of erythromycin has been more restricted in the community permitting the majority of strains to remain sensitive. Repeated observations have indicated that the emergence of antibiotic resistant strains has correlated with the extent of the use of each newly marketed antibiotic. Any originally effective anti-staphylococcal agent that is consistently utilized in a hospital population may result in the selection and accumulation of strains resistant to it.

The use of antibiotic combinations in the treatment of staphylococcal infections is based essentially on two possible beneficial results: to effect synergy and secondly to delay the appearance of those clones resistant to one or both antibiotics. Although synergy of antibiotics against staphylococci has frequently been demonstrated in vitro, there is a paucity of evidence to suggest that this occurs in the treatment of patients. This is in contrast to the recognized beneficial effect of selected drug combinations in the therapy of tuberculosis, enterococcal endocarditis and brucellosis. Respecting the demonstrable capacity of staphylococci to develop resistance in vitro, it is suggested that such antibiotics as erythromycin, novobiocin, or oleandomycin should be combined with an additional drug, including chloramphenicol or bacitracin. Combination therapy should be restricted to

the more significant infections, particularly those of hospital origin. It should be emphasized, however, that the prime problem in antibiotic resistance to staphylococci is not that of unsusceptible clones propagating and becoming dominant in the treated patient, as in tuberculosis, but rather the acquisition of resistance by transfer or re-inoculation of the patient with a new strain from an exogenous source. Whenever combination therapy is indicated, the organism should be sensitive to both agents used as demonstrated by in vitro testing, preferably by the tube dilution technique. If the Staphylococcus isolated is found sensitive to penicillin, there are few instances in which it should be used in combination. The addition of a second antibiotic usually results in an indifference rather than synergy.

Several more recently developed antibiotics have demonstrated some degree of cross resistance in vitro and in some instances suspiciously so in vivo. Although not absolute, cross-resistance of erythromycin with carbomycin, spiramycin, and oleandomycin does occur. Antibiotic combinations have been used in attempts to delay the accumulation of resistant strains in hospital populations. Although this is plausible, a beneficial effect has not been adequately demonstrated.

The ideal antibiotic to treat staphylococcal infections has yet to be obtained. In addition to the recalcitrance resulting from the complex interactions of the host and this bacterium, the effectiveness of each of the presently available anti-staphylococcal agents is limited because of the impetus they give to resistance. The frequency with which resistance to these agents occurs depends upon the extent of their usage. It is possible that as new effective antibiotics are developed and carefully used, there will be less tendency for accumulated resistance to develop to a single drug. In any hospital, at least one antibiotic should be held in reserve and used specifically to treat only the more serious infections.

Maternal Mortality Institutes

MADISON: Tuesday, June 23, State Medical Society, 330 E. Lakeside Street.

LA CROSSE: Wednesday, June 24, St. Francis Hospital, School of Nursing, 615 S. Tenth Street.

EAU CLAIRE: Thursday, June 25, Luther Hospital, 310 Chestnut Street.

TIME: Madison, 7:30–10:30 p.m.; LaCrosse and Eau Claire, 2:00–5:30 p.m.

FOR: Physicians, hospital administrators, obstetric nurse supervisors, and nurse anesthetists.

NO REGISTRATION FEE: Costs underwritten by the State Board of Health and the State Medical Society.

PROGRAM: Moderator, T. A. Leonard, M.D., Chairman, Study Committee, Maternal Mortality Survey, State Medical Society of Wisconsin.

Catastrophic Situations in the Delivery Room, by William Kreul, M.D., Racine.
Care of the Pregnant Woman Over 40 Years of Age, by George S. Kilkenny, M.D., Milwaukee.
Why Deaths from Ectopic Pregnancies?, by Frederick J. Hofmeister, M.D., Milwaukee.
Trauma During Delivery and Its Consequences, by T. A. Leonard, M.D., Madison.
Infection—A Continuing Cause of Maternal Mortality, by William Kiekhofer, M.D., Madison.

ACADEMY CREDIT: 4 hours of Category I credit for all Academy members who attend.

PROGRAM SPONSORED BY: State Medical Society of Wisconsin, Wisconsin State Board of Health, and Wisconsin Academy of General Practice.

SPECIAL TO THE JOURNAL

Fatal Sensitization Reaction Following the Use of "Pitocin"

Report from the
Wisconsin Maternal
Mortality Study Committee
of the State Medical Society

The use of the oxytocic principle of the posterior pituitary gland, commonly known by the trade name of "Pitocin" seems to be a well-established procedure in obstetrical practice. When administered with proper safeguards as to dosage, method of administration and proper indications, the risks both to the mother and the fetus have been considered minimal. There are, as with all drugs, certain untoward reactions which might occur. The Wisconsin Maternal Mortality Study Committee has had the opportunity of reviewing two cases where sensitization to the oxytocic factor was the immediate cause of the maternal death. These incidents draw attention to the fact though sensitization rarely is a factor in the use of this particular drug, the practice is not entirely free from danger. The following is a brief summary of one of the two cases:

Case Report: A multigravida III, para II, age 30 years, had experienced an uneventful pregnancy except for a trace of albumin from the seventh month to term. The patient had been normotensive and showed no other signs of toxemia. She was admitted to the hospital at term with ruptured membranes. Physical examination was reported to be negative. F.H.T. were present. Labor had not been spontaneously initiated. Since the patient was at term with ruptured membranes, an elective induction of labor was attempted by the administration of two minims of Pitocin intramuscularly. Within five minutes following the administration of the drug the patient, who had been sitting on a chair beside her bed chatting with another patient, suddenly became deeply cyanotic, collapsed, and fell to the floor and could not be revived.

The Study Committee felt that in all probability the death was due to anaphylactic shock from the oxytocic factor, Pitocin, it being the drug used in this case. It was classified as a nonpreventable death although the dose of Pitocin was rather large especially when administered as a single dose and given intramuscularly. Clinical investigations seem to suggest that the use of the drug in dilute intravenous solution is more desirable than the intramuscular injection route. The latter has a wider reported variation in individual response with momentary rises in blood pressure especially in toxic patients.

Reports of sensitization to the posterior pituitary hormone are exceedingly rare. Simon and Ryder[1] have shown that extracts of the posterior pituitary do contain a substance capable of acting as an antigen and that this substance is neither the vasopressor nor the oxytocic factor. From the authors' observations sensitization reactions never were seen to have occurred after the first injection, but only after the drug had been administered on several occasions. This might suggest that the history of previous injections is important to elicit from the patient, and if previous administrations had been made, to withhold further use of the drug until preliminary skin testing indicates nonsensitization.

A similar precautionary measure might be taken in the use of the ovarian hormone, Relazin, which has during recent years been administered intrapartum for various obstetrical complications. The Study Committee has recently received a verbal account of a severe and near fatal anaphylactic reaction following the use of this hormone intrapartum. The same precautionary suggestion might be followed as with the oxytocic factor in that preliminary skin testing might be a rewarding procedure both to the patient and the physician.

REFERENCES

1. Simon, F. A., and Ryder, C. F.: Hypersensitiveness to pituitary extracts, J.A.M.A. 106:512–515 (Feb. 15) 1936.

Rehabilitation of Physically Handicapped Residents in Nursing Homes

By PAUL F. FLEER*

Green Bay, Wisconsin

REHABILITATION IS THE process of helping handicapped people to regain their highest possible functional level by training them to use what powers they still have to compensate for those they have lost. This includes consideration of the emotional factors attending physical impairment and even extends into modifying the environment where possible to permit maintenance of maximum usefulness.

There is a large number of people living in Wisconsin nursing homes who can be helped appreciably to attain the goals based on this definition. Probably every nursing home in the state has residents who could learn to be more functionally independent and so to be happier, more useful, and more dignified human beings.

A demonstration rehabilitation project in nursing homes, currently being conducted in Green Bay by the Wisconsin State Board of Health, has shown clearly that 15 to 20 per cent of physically handicapped nursing home residents can achieve significantly greater functional levels. A majority of these suffer from the great chronic cripplers—strokes, hip fractures, and arthritis with the accompanying emotional factors of hopelessness, uselessness, and apathy.

The following cases are cited as examples:

Case 1: M.M., a 54-year-old married woman, six years ago suffered a stroke which caused a right hemiplegia with aphasia. She also had moderate hypertension and diabetes. She made futile attempts at speaking and only used her unaffected extremities for eating and propelling her wheel chair once she was placed in it. She could write.

She was examined by her physician on February 6, 1959, and was recommended to the Board of Health Rehabilitation Program for training in functional activities and speech stimulation.

Results to date (April 1, 1959): Mrs. M.M. has learned to dress herself, wash herself, comb her hair, transfer to wheel chair and back with little assistance, and can express herself verbally in sentences. She is looking forward to living at home again.

Case 2: M.L., an alert 83-year-old widow, suffered an intertrochanteric fracture of the left hip in April, 1958. This was treated surgically with pinning. In July, 1958, she was transferred to a convalescent home where, except for several hours of sitting in a chair each day, she spent all her time in bed. She did not dress, wash, or groom herself, and stood up only briefly with assistance when transferring from bed to chair and back.

On December 15, 1958, she was examined by her physician, who recommended she be placed on the Program with strengthening exercises and functional training, leading to ambulation as soon as possible.

Results to date (April 1, 1959): Mrs. M.L. now bathes, dresses, and grooms herself completely, can transfer from bed to chair and back alone, and walks 100 feet several times a day with no help (but accompanied) using a light walker. Her daughter is anxious to have her at home again.

Case 3: P.N., a gruff, thin, 54-year-old man has had rheumatoid arthritis for over six years and has been almost completely bedridden during the last year with pain, multiple deformities and contractures, and weakness. He had fractured his left hip two years ago and his right hip one year ago, both being pinned and healing satisfactorily. He could do little more for himself at the time of evaluation than wash his face and hands, roll over in bed with difficulty, and feed himself. He was examined by his physician who recommended active and passive exercise and functional training. He also prescribed a course of steroid therapy.

Results to date (April 1, 1959): Mr. P.N. can now wash, dress, and groom himself completely, and can use a wheel chair independently. Also, he can get up from his chair and walk 100 feet alone using crutches. Community living again becomes a real possibility.

*Physical therapy consultant in the Green Bay District Office of the Wisconsin State Board of Health.

All three of these people were discouraged, dependent, and unhappy. Yet, when given a chance, they all expressed a willingness to try to help themselves.

Two of these people are receiving assistance from County Welfare, the amount of which is determined by their place of residence and their degree of dependence. The use of taxpayers' money to support these people makes their rehabilitation a matter of not only human but also of general public interest. Each person has loyal children who wish the very best for their parents. The nursing home personnel seek to provide the best care for their residents. The patients' physicians, by their active concern and leadership, can unite and direct all of these resources for the rehabilitation of their handicapped patients.

The number of elderly physically handicapped people in the state of Wisconsin is growing steadily. They present a variety of physical, social, emotional, and economic problems. A medically directed rehabilitation approach (the third phase of medical care) can effectively treat these problems.

Report of a Conference on Drug Therapy in the Treatment of a Variety of Diseases

Leukemia, serious skin diseases, eye and intestinal disorders, and others, as well as rheumatoid arthritis, are now being treated successfully with synthetic adrenal hormones.

Reports on progress in treating a variety of diseases were made before more than 400 scientists who gathered in New York in December to review a decade of therapy with these drugs, called "the anti-inflammatory steroids"—from the original, cortisone, to the newest, dexamethasone.

The conference was sponsored by the New York Academy of Sciences, Merck Sharp & Dohme Research Laboratories, and the Schering Corporation.

Use of these steroids has brought about a "revolution" in the treatment of various blood disorders, including leukemia, reported Dr. William Dameshek of Tufts University. He said they have become an essential item in the management of leukemia, autoimmune hemolytic anemia and other disorders of the blood.

"In some cases," he said 'the steroids' "modify the course of acute leukemia in relatively small doses; in massive doses, they may often induce complete clinical, hemotological and bone marrow remissions." (They do not, however, "cure" the disease.)

Dr. Daniel M. Gordon, Cornell University, reported on seventy patients who had been treated for eye diseases with dexamethasone with "a high degree of success."

"Dexamethasone," Dr. Gordon said, "is a highly potent anti-inflammatory steroid which has approximately twelve times the potency of prednisone . . . . Side effects have been minimal, in view of the high doses necessary in ophthalmic disease, especially in chronic patients.

Dr. Victor H. Witten, New York University, discussing skin disorders, commented: "Administration of these corticosteroids have made it possible to . . . rehabilitate patients with heretofore disabling dermatoses, and to save the lives of persons with previously fatal diseases of the skin."

Dr. Leon Goldman, University of Cincinnati, also reporting on the treatment of skin disease, stated that dexamethasone was successfully used in the treatment of 46 children and 208 adults, with "no gastrointestinal reactions . . . observed so far." (Gastric distress has been described by some physicians as an adverse "side effect" of the steroids.)

Dr. Walter L. Palmer, University of Chicago, offered evidence that this "weakness" of the steroids may be the result of confusion.

"The evidence does not warrant the conclusion that peptic ulcers occur excessively in—patients receiving steroid therapy," he reported. "Of 240 patients with chronic ulcerative colitis treated with large amounts of steroids, nine had histories of ulcers previous to treatment with the steroids . . . 'but', "of the 240, only two developed ulcers."

Dr. Samuel C. Bukantz, Children's Asthma Research Institute, Denver, reported that the steroids were uniformly effective in controlling allergic symptoms and that, with dexamethasone as with the older steroids, very few and only minor adverse reactions were observed.

Dr. Margaret H. D. Smith, also New York University, reporting on the successful use of steroids in childhood tuberculosis, said there is "a definite advantage" to supplementing anti-bacterial drugs with small doses of prednisone.

Sponsored by Section on Pathology
State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

The Role of Fat Embolism Complicating Trauma

Guest Editor: B. D. HARROLD, M. D., F. C. A. P.
Monroe, Wisconsin

Case Presentation*

Jan. 17—11:50 A.M.: This 74-year-old white man lost his balance and fell from about the second rung of a ladder. He struck the right side of his head, right chest, and hip on the floor. He was not unconscious but was "dizzy for a bit."

12:30 P.M.: The patient was seen in a physician's office complaining of pain in the right, lower anterior chest aggravated by cough, inspiration or position change. The patient appeared to be in some distress, but stated that coming to the doctor was not his idea.

Examination showed a superficial abrasion of the right parietal area and a small laceration of the right elbow. Blood pressure 175/90, pulse 80, with frequent extrasystoles, no murmurs. He had tenderness over a small area at the junction of the right costal margin and midclavicular line, but there was no pain on compression of the chest if this region was avoided. The anteroposterior diameter of the chest was increased and the breath sounds distant throughout. The abdomen was soft without particular tenderness.

He was sent home with prescription for analgesics and instructed to rest overnight.

5:00 P.M.: Patient was seen at home complaining of increased pain in his chest involving a slightly larger area in the same region. He also complained of pain in the right hip and stated, "my whole right side hurts." He had had one emesis of thick mucus. Examination was unchanged. He was given a narcotic intramuscularly and an ace bandage was applied to his chest.

Jan. 18—8:00 A.M.: Physician was called to see patient at home because of frequent small emesis of dark blood ("coffee ground"). He had a long history of indigestion with burning aggravated by coarse or highly flavored food.

Blood pressure 165/90, pulse 80, temperature 101.4 F. rectally. Examination was otherwise as before except for definite tenderness over entire course of the right eighth, ninth, and tenth ribs.

The patient was transferred to the hospital and a 6-foot chest film taken on admission. This x-ray showed a small localized area of increased density just above the left diaphragm. On first appearance it seemed compatible with an area of pleuritic thickening or a small localized area of atelectasis. The chest was otherwise normal. The patient had a history of severe pneumonia on the left side many years ago. He also stated that for many years he had had a chronic cough which was productive of several tablespoonsful of thick whitish material on arising. He was put on complete bed rest, and an ulcer type of diet.

8:00 P.M.: "Resting fairly comfortably. No hematemesis since 10:00 A.M." Hemoglobin: 12 gm.%, white blood count: 13,750, segs: 34%, stabs: 43, lymphocytes: 13, monocytes: 9, basophils: 1, urine specific gravity: 1.017, albumin: 3 plus, sugar: 0, microscopic: epithelial cells.

11:15 P.M.: The nurse heard a crash from patient's room and found him on the floor. He stated that he had got up to use the urinal and had lost his balance. He was well oriented at this time and stated that his chest now hurt more. He had a small laceration above the left eyebrow. He was able to get back in bed with help, but shortly thereafter became dyspneic and cyanotic. He began coughing up large amounts of thick white sputum. At 12:00 o'clock midnight his temperature was 104 F., blood pressure 200/80, pulse 120.

Jan. 19—3:00 A.M.: Blood pressure 115/60, pulse 100. "Oxygen started. Squeaking inspiratory and expiratory rales throughout entire chest. Diminished resonance in left lower lung fields."

*From St. Clare Hospital, Monroe.

A bedside chest x-ray was taken. Comparison with the film from the previous day revealed a marked change with a manyfold increase in the area of increased density in the left lower lung field. The left diaphragm was elevated and there was a minimal shift of the heart to the left. These findings were felt to be most suggestive of pulmonary infarct, but atelectasis or pneumonia could not be excluded. No rib fractures were seen.

A thoracentesis was done in the left eighth and also seventh interspaces without obtaining any fluid. Antibiotic was started as well as potassium iodide and carbon dioxide inhalations.

8:00 A.M.: "Improved. Breathing more easily."

6:00 P.M.: Urinary output was very small despite a large oral fluid intake. Catheter inserted and 1050 cc. urine obtained.

Jan. 20—9:00 A.M.: "Still some rales in bases, but feeling better." Blood pressure 125/60.

3:00 P.M.: "Unable to keep sippy feeding down. Vomiting mucus. Complaining of gas. Blood pressure 105/50, temperature 102 F. rectally. Harris Flushing given with good results. Sippy diet stopped and soft bland diet substituted."

Jan. 21—9:00 A.M.: "Seems weaker and it is difficult to get him to cough." Nonprotein nitrogen: 79 mg.%, FBS: 210 mg.%.

Jan. 22: "Seems better. Says that his chest no longer hurts him when he coughs. Chest not tender to palpation." Temperature 99.8 F. Urinalysis negative except for a trace of albumin.

12:00 N.: "Coffee ground emesis again and is complaining of gas pains."

6:30 P.M.: "More comfortable, but very thirsty." Temperature 102.4 F.

Jan. 23—9:00 A.M.: "Feeling better. Blood pressure 150/50. Up in a chair for a short period."

12:00 N.: "Began having coffee ground emesis again. Temperature 103 F. Respirations becoming labored."

7:00 P.M.: "Pulse 96, respiration 26, temperature 105 F. Extremely restless and confused."

Patient had taken no fluids since morning so 1,000 cc. of 5% glucose in saline and 1,000 cc. of 5% glucose in water were given. Because the urine was found to contain 2% glucose while second intravenous was running, lactate Ringer's solution was substituted for the glucose. Later the urine was still 4 plus for glucose and a small dose of insulin was given.

9:00 P.M.: Blood pressure 160/80, temperature 106.8 F. "Pulmonary congestion increasing rapidly. Extremely agitated."

Jan. 24—12:00 M.: Temperature 106.8 F., pulse 128, blood pressure 90/40. "Semicomatose, clinitest urine sugar and acetone: negative."

3:00 A.M.: Cheyne-Stokes respirations.

3:45 A.M.: Expired.

Discussion

(Neurosurgeon)

Dr. A. Y. Gerol: As we attempt to make the diagnosis here, we have the same uneasiness that is experienced by the poor lineman who senses he is to be mousetrapped. We both know it is about to happen, but when and where?

It is not clear why this 74-year-old man fell, but I believe both the cause of his loss of equilibrium and the subsequent head, chest, and arm trauma were not directly culpable for the subsequent events except as initiating factors. This septuagenarian sustained minor injuries to a chest which was already emphysematous, and, we might parenthetically add, capable of less than optimal pulmonary reserve. His moderate hypertensive arteriosclerotic cardiovascular disease in the presence of a head and chest injury, however, removed this patient from the status of one who might have been easily observed at home; he was a patient who required hospitalization and the exercise of the greatest conservative medical art. As proof of this, we see that this man, discharged with the customary precautionary instructions, had great difficulty within 5 hours. At this point the well-meaning physician administered a narcotic to reduce his pain. We cannot castigate this particular pain relieving ritual too strongly. It is only by sheer serendipity that more complications do not follow the profligate misuse of narcotics in patients who have head injuries. This is even more contraindicated in those elderly patients who have so-called "minor head injuries." The prognostic possibilities of pupillary change is masked by narcotics; the hypnotic effect of large doses of narcotics obtund the individual so that a clear evaluation of his level of consciousness is prevented. The hypnotic hypopnea produces a relative anoxia and increased cerebral edema. Any patient suffering from a head

injury, but especially those over the age of 60 who manifest hypertension, or evidence of arteriosclerotic cardiovascular disease, should *under no circumstances* be given any medication which might obtund the level of consciousness, interfere with the pupillary reflexes, or change the respiratory rate. Despite his narcotic, the patient survived the night only to present in the morning the first of the diagnostic dilemmas (the hematemesis and the pyrexia). We know that the patient had suffered from the all-obscuring nonentity termed "indigestion", but what we do not know is whether he had ever had melena or hematemesis before. Moreover we do not know whether he had bitten his tongue in the course of his fall or had had epistaxis subsequent to his fall. In any event, he vomited quantities of blood which I presume was recent and not related to direct trauma. The pyrexia and the splinting of the chest with the enlargement of the painful area all indicated a possible fractured rib or ribs, with concomitant subjacent pneumonia or atelectasis. Because of these possibilities the patient was admitted to the hospital and for the first time x-rays were made.

We might pause here to condemn another practice, and that is, the failure to make the skull roentgenogram at the time the patient initially presents after trauma. Medical science is a technique of prognosticating from present signs and symptoms, and past experience, the future course. Only with complete present knowledge can the future of any particular condition be predicted. Any "head injury patient", especially those in the first two decades and those of the fifth decade or older, should be given the benefit of immediate adequate x-ray. That is an anterior-posterior, posterior-anterior and right and left lateral skull roentgenogram. There has never been any series reported of patients, following minor head injuries, whose subsequent course was evaluated comparing the paucity of presenting signs against the prognostic significance of the initial x-ray. In 100 consecutive skull x-rays made in this rural hospital, following minor head injuries, there were 8 skull fractures, two of which required subsequent operative intervention. Furthermore, in any patient who is emphysematous a change in the CO_2 tension due to pulmonary dysfunction may increase cerebral edema. The volume increase of brain substance after a minor local cerebral contusion followed by oxygenation in an emphysematous patient may be sufficient to produce tentorial herniation. In this particular patient who had, no doubt, senile cerebral changes, who suffered a head injury, and who had moderate pulmonary reserve, any disturbance of the tenuous balance of the cerebrovascular blood flow might have been sufficient to force him into a precarious cerebral state; but again I do not think that it was a cerebral mass lesion clot that destroyed this individual.

The chest film demonstrated, that although his initial injury was on the right side, his pulmonary pathology was on the left and more diagnostic road blocks are laid in our pathway by the history of the old pneumonitic process. Thirty-six hours following his injury the man was then placed at bed rest under observation. At 8:00 o'clock the following night he suffered the second and last head injury. One might parenthetically note that the discussant's role tonight would be much simpler if this last head injury were to be ignored. We will forthwith do this because we feel it again has only indirect bearing upon the subsequent course. Within three hours after this last injury, the patient manifested all the signs and symptoms of myocardial insufficiency and pulmonary edema except for the lack of tachycardia. A chest x-ray again demonstrated an extension of the left sided process. Doctor Zach, would you mind at this time discussing the various chest films? The injury which occurred on the right side was manifested by pulmonary changes on the left; I have never heard of it, but I believe a phenomenon of "chest contracoup" was not the instigation for discussing this case.

Dr. R. G. Zach: The request for x-ray of the chest stated that there was an injury to the right chest. I commented in the report that the area of increased density was on the left which is opposite the side of injury. There were no rib fractures seen on these films, but if alignment is good, fractures often cannot be visualized unless moving grid films are taken. It is important in any case of suspected rib fracture that several views of the ribs, including moving grid films, be requested.

Doctor Gerol: The rather marked cyanosis, respiratory change, and the sudden hypotension indicated, however, in the presence of his neurologic change, that a pulmonary infarction had occurred with a possible concomitant cerebrovascular insult. The usual conservative measures were sufficient to re-

verse the process and the patient responded alarmingly promptly to this course of action. The response of the initial conservative management resulted in a fairly clear interval of several hours, and then there occurred another hematemesis, a resurgence of the pulmonary difficulty compatible with pulmonary congestion, the intercurrent diagnosis of diabetes or a possible diabetic state finally ushering in a striking pyrexic course and exodus.

As we stated at the beginning, I do not think that the head injury is culpable, but I do think that the cerebral symptoms and the pulmonary symptoms are related insofar as they both followed an embolic phenomenon. Pulmonary embolism in the aged or in persons suffering trauma may be due to phlebothrombosis, air embolism, free myocardial clots with or without myocardial infarct, fat embolism, and blood dyscrasias.

First, let us for the moment consider the possibility of this man having had a phlebothrombosis with a subsequent pulmonary infarct. At the time of his accident he manifested no severe injury to the larger vascular structures or to major portions of the body which might have resulted in a local clotting phenomenon. But this is a weak thesis. His subsequent clinical course was not that of a sudden embolization and a pulmonary infarct due to a clot. At no time was there any hemoptysis. At no time was there the sudden hypotensive state (except at the very end) one associates with any pulmonary infarct. He did not have the catastrophic onset and gradual resolution one usually associates with a migrating clot. I am sure that if he had had any vascular abnormality of the extremities, it would have been mentioned in the protocol. There is no mention of aberration of peripheral pulses, change in the color of the extremities, or of pain which one usually finds in this condition at this age.

Secondly, although the patient did suffer a thoracic injury, the radiologist failed to find any rib fractures. Doctor Zach did not find, and I do not see, any emphysematous blebs or free air in the pleural cavity or the mediastinal tissue. There is the questionable shift of the mediastinal structures from the right to the left, but the thoracentesis failed to aspirate air or fluid within the chest. The course one usually finds following an air embolism and its cerebral manifestations (pain, hemiparesis, hemianesthesia, profound change in the state of consciousness) is not noted here. One may argue that the hematemesis and the pyrexic course and the change of the vital signs might all have been based on hypothalmic injury subsequent to air embolic phenomenon, but air embolism classically produces injury in the major vessels of the brain and is not so neuroanatomically discrete as the patient's clinical state indicated.

Third, let us consider the possibility that this man had had a myocardial infarct. It has long been known that myocardial infarction will result in the production of small showers of emboli in the first 12 to 24 hours. This phenomenon is the basis of a rather profound picture of multiple pulmonary infarcts, but these are very rarely associated with cerebral manifestations. We recall a 49-year-old nurse who, following a celiotomy for intestinal obstruction, developed a myocardial infarction and evidenced the small emboli producing the pulmonary infarcts the second day after her myocardial insult. At no time were there any profound cerebral manifestations or other evidence of embolic phenomenon. The change in the vital signs was not intermittent; the hypotensive state following the infarct and the subsequent emboli was constant until the showering and the progress of the infarct had been controlled.

Fourth, one might argue that the freeing of small myocardial vegetations (due to some intercurrent pathophysiologic mechanism subsequent to the injury without a myocardial infarct) would have a similar clinical picture.

Fifth, I do not think that this man had any blood dyscrasia. For example, I do not believe he suffered the pan thrombosis one finds in carcinoma of the pancreatic tail; if he did and if the carcinoma had eroded through into a small intestinal vessel, he would not have suffered the intermittent minor hematemesis and the rather vague intestinal symptoms. What we are asked to explain here is why the patient's clinical pattern varied so much and what influence the hematemesis and the diabetic state had to play.

I would think that this is an individual who suffered from fat embolism and at this point I feel that the mousetrapping procedure which we alluded to in the opening remarks is complete.

The comparatively minor head and chest injuries could not per se cause such severe diffuse cerebral and pulmonary dysfunction. The diagnosis may be made from the clinical course, the rather unusual association of cerebral, pulmonary, and gastrointestinal symptoms, the profound overwhelming shock and pyrexic state out of all proportions to the suspected etiology.

In the end, although a lumbar puncture was not performed on this patient, I do not think that his hematemesis was due to the diapedesis one may find in cases of increased intracranial pressure or the so-called Cushing or Curling ulcer. I do not think the bacterial sepsis and embolization were the cause of the rather profound shock and pyrexic preagonal manifestations. Therefore, I believe that the diagnosis would have to be death due to:

(1) pulmonary and cerebral embolization, due to free floating fat subsequent to a minor trauma, (2) diabetes mellitus, (3) hypertensive arteriosclerotic cardiovascular disease, (4) pulmonary emphysema, senile, (5) benign hypertrophy of the prostate gland (to account for the vesical distention).

Pathological Discussion

Dr. B. D. Harrold: At autopsy this patient was found to have multiple fractures of the ribs over the right thorax with regional hemorrhage. There were contusions over the right hip with abrasions over the right elbow and eyebrow as well as contusions over the right parietal region. There was only slight bilateral hydrothorax and peritoneal effusion. There was moderate pulmonary congestion and edema with focal pulmonary hemorrhage. There was early bronchopneumonia. There was hemorrhage into the right adrenal with a rather large clot of blood extending throughout the medulla. The right adrenal measured an estimated 7 x 5 x 5 cm. The left adrenal gland, however, was essentially normal in size and shape with the usual corticomedullary pattern on cut section. The brain was somewhat atrophic with widening of the sulci and narrowing of the gyri. The brain was symmetrical and equal in consistency. On cut section there were multiple small speckled reddened areas in the region of the dentate nucleus in the cerebellum. Elsewhere on cut section through the brain there was slight speckled fine reddening in the white matter. There were no other significant findings on gross examination.

However, on microscopic examination there were fine small vacuolated spaces within small blood vessels in the lungs. Fat stains of the lung revealed relatively numerous small globules of fat within arterioles and capillaries in the lung. There were only a relatively few collections of fatty vacuoles within the kidney and brain.

It is interesting to note that the gross findings are not striking and certainly there would not seem to be sufficient gross pathology to explain death. Although there was considerable hemorrhage into one adrenal, the other adrenal was apparently well preserved. It was felt that the degree of fat embolism demonstrated was sufficient to explain the mode of exodus in addition to early bronchopneumonia and slight adrenal insufficiency.

This case has been presented to emphasize the role of fat embolism complicating trauma. Unfortunately in the past, there have been numerous conflicting reports with regard to the incidence of fat embolism.

According to Dunphy and Ilfeld, "the condition is sufficiently rare and the manifestations are so easily ascribed to 'shock' or 'heart failure', that many are still not only ignorant of its features but also actually doubt its occurrence." "Many surgeons of great experience in World War II believe they did not see a single case." Warthin considered that fat embolism from traumatic lipemia was not rare and that the condition was the most frequent cause of death following fracture of long bones when infection was not present. Many studies including one from the Korean conflict revealed that approximately 60% of injuries were associated with fat embolism. Other studies have revealed an incidence of 40% to 60% fat embolism associated with trauma and it is estimated that in approximately 20% of these cases fat embolism was severe enough for cause of death. It has been stated that the incidence of fat embolism is directly proportional to the interest of the surgeon and the pathologist in the case.

Fat embolism has been said to be associated particularly with trauma to adipose tissue and classically associated with fracture of long bones. However, trauma to fat pads including operative procedures especially radical breast amputations are also responsible for a certain degree of fat embolism. There

are multiple miscellaneous conditions associated with fat embolism including extensive burns, fat necrosis, some cases of poisoning, severe cases of diabetes with lipemia, marked fatty change in the liver, and post mortem processes.

It would seem useful to review some of the clinical findings associated with fat embolism. Characteristically there is injury followed by a lucid interval of from three or four hours to three to eight days. The subsequent symptoms may be cerebral and/or pulmonary in character. The cerebral symptoms include vague variations in consciousness, irritability to stupor, and loss of consciousness. There may be evidence of headache with vomiting, halucinations, convulsions, etc. The pulmonary symptoms are those of dyspnea, cyanosis, rales, and cough (which may or may not produce blood-stained sputum). Examination may reveal increased pulse rate with fever up to 106 F. to 107 F.

Fat embolism has been known to simulate shock, pulmonary edema, pneumonia, and intracranial injury and therefore complicate diagnosis. Additional findings may be petechiae which are supraclavicular and conjunctival in location. Frequently funduscopic examinations reveal fat globules within the retinal vessels with small areas of hemorrhage. This may be one of the simplest and most direct aids in diagnosis of a fat embolism early in the course of the disease.

Chest x-ray frequently reveals multiple floccular densities, haziness, or areas of increased density resembling pneumonia. These roentgenologic changes often increase, even though the patient is clinically improving. Such a finding should suggest fat embolism.

Laboratory findings often reveal progressive anemia without evidence of bleeding or other blood loss. After usually five days, it is often possible to find fat globules in the urine. It is important to note that the fat will float on top of the urine and, therefore, a catheterized specimen must be obtained, completely emptying the bladder. The urine should be sent to the laboratory and a "sizzle test" performed. This test consists of passing a wire loop under the surface of the urine and holding it over a Bunsen burner. The fat mixed with urine sizzles and pops and thereby the name, "sizzle test." Occasionally fat globules have been demonstrated in the blood on dark field examination. Fat globules have also been demonstrated in sputum, however, they sometimes occur in sputum under normal circumstances.

At autopsy, diagnosis of fat embolism is often overlooked because usually there is sufficient gross pathology associated with trauma to explain the death. In addition microscopic examinations of patients dying as a result of trauma usually are relatively brief and certainly rarely include frozen section of lung and stain for fat. Such a procedure requires special handling and special interest. Frequently the lung is floating in formalin with fatty tissue and unless the pieces of lung are handled carefully, washed, and the outside portions cut away, the fat on the surface may cause confusion. Obviously in order to prove the diagnosis, it must be possible to demonstrate these fat globules within small blood vessels. Relatively thick frozen sections of lung, kidney, and brain should be stained for fat.

Treatment includes early immobilization of fractures, in addition to the usual supportive measures. One important addition is that of oxygen by closed mask. Oxygen by closed mask with positive pressure often results in dramatic improvement and this form of therapy is often overlooked unless there are definite prominent pulmonary symptoms. Unfortunately, the use of oxygen is often not even mentioned in the literature.

In conclusion, fat embolism is often overlooked as the result of the general belief that it is unusually rare and that there is no treatment. Fat embolism is also overlooked, due to the fact that it may simulate shock, pulmonary edema, pneumonia, and intracranial injury. Some cases of irreversible shock without extensive tissue necrosis or sepsis are likely due to a combination of blood loss and fat embolism. Please note the interesting clinical correlation in this case: (1) "relatively" minor injury, (2) lucid interval, (3) vomiting, (4) possible faint spell or dizziness with fall and attempt to get up, (5) dyspnea, cyanosis, and cough, (6) physical findings over left chest, though injury was on right, (7) marked increased density in *left* lower lung lobe by x-ray, (8) anorexia, vomiting, (9) pulse and blood pressure variable, (10) temporary clinical improvement, (11) subsequent fever with cerebral symptoms, of restlessness, confusion, agitation, and semicoma.

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COMMENTS ON TREATMENT

Cough Suppression in Children

By HARRY BECKMAN, M. D.
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THE DISTRESSING NATURE of nocturnal coughing spasms in children, so familiar to parents and practitioners, is further attested by the half-hundred or more antitussive preparations stocked by a busy pharmacist. It is not improbable that most of these proprietaries win their popularity more through their pleasant taste than their antitussive properties. Actually, remedial agents in cough are not easy to evaluate. Gregorre *et al.*[1] of Montreal, point out the two principal causes of the difficulty: first, cough is often of sporadic nature and short duration; second, patients who are hospitalized with cough secondary to underlying disease will often have their cough relieved as specific or other symptomatic therapy ameliorates the primary condition. It is fortunate that experimenters in this field have ceased to judge the efficacy of "expectorants" on the basis of the amount of sputum produced, since respiratory tract fluid can be appreciably liquified, as revealed by postural drainage and bronchoscopic suction, without the action being reflected in the sputum. The newer experimental approach is through production of experimental cough in normal individuals by inhalation of irritant aerosols, and it has already produced some interesting findings.

There is a rash of new antitussives which are being tried both experimentally and clinically. Unfortunately, most of the articles descriptive of these studies leave something to be desired, because conclusions appear to be based on too little supporting evidence. A preparation enjoying some current popularity is Tussionex, which is a combination of resin complexes with dihydrocodeinone (Hycodan; Dicodid) and an antihistaminic agent. It is claimed that antihistamines potentiate the antitussive effect of dihydrocodeinone, while the ion exchange resin forms complexes with the active agents, from which they undergo sustained release into the gastrointestinal tract.

Townsend,[2] of the University of Rochester, found that the optimal dose of this combination was ¼ teaspoonful every 10 to 12 hours for infants under age one, ½ teaspoonful for children age 1 to 5, and 1 teaspoonful for those over 5. Personal variations, however, demanded adjustment of the dose. If a dose was given in the early afternoon and again at bedtime, complete relief from cough was obtained for 10 to 12 hours. Side effects were rare. Constipation occurred in only 2 of the 269 patients treated. Facial pruritus occurred in 5, severe enough to stop the medication in 2. Lethargy seemed related simply to personal dosage variations and diminished when the dose was lowered for the patient so affected.

2831 North Shepard Avenue.

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The Country Doctor a Century Ago

SECTION ON MEDICAL HISTORY

Much has been written of the country doctor of a century ago. He was an important figure in Wisconsin pioneer life. An individualist in an age of individualism, he conformed to no set type.

The equipment of the country doctor in the early 1800's was simple: mortar and pestle, a set of balances, some home-made splints and bandages, a few drugs, possibly a small assortment of instruments, perhaps a pewter bedpan, a few simple syringes, and pewter or crockery hot-water bottles.

Occasionally a doctor had a pulsometer—a glass, dumbbell-shaped container about six inches long—filled with colored liquid. When the patient held one end in his closed hand, air bubbles would rise to the other end. This result was, of course, a simple physical rather than physiologic action, and bore no actual relation to the pulse. But it served to convince the patient that he had had a more thorough and accurate diagnosis.

By the late 1830's most of the better equipped doctors also carried a stethoscope, a set of tooth forceps, and a few obstetrical instruments. In the absence of complicated equipment for diagnosis he relied upon his fingers, eyes, ears and nose.

Naturally the doctor in those days had a horse and saddle bags.

The following is a contemporary description of the country doctor's life by a member of the profession:

"He had to be his own pharmacist. He made his own pills and tinctures, compounded all his medicines, and generally carried all he required in the saddle bags, wending his way from house to house, always welcome and often regarded as an angel of mercy, although his homely garb and rough appearance looked anything but angelic.

"His life was unquestionably one of peril, toil and privation. The country was new and thinly settled, and his rides were long and solitary. His patients were scattered over a wide expanse of territory. His travel was mostly performed on horseback, and its extent and duration was measured by the endurance of himself and his horse. He struggled through almost unfathomable mud and swamps and swollen streams.

"He was often compelled to make long detours to cross or avoid the treacherous slough. His rest was often taken in the saddle, sometimes in the cabin of the lonely settler.

"From necessity he was self-reliant and courageous. Every emergency, however grave, he was generally compelled to meet alone and unaided, as it was seldom assistance could be procured without too great an expenditure of time and money.

"His fees were small and his services were often paid for in promises, seldom in money, of which there was but little. The products of the country, called by the people 'truck', was the general and most reliable circulating medium, and with this the doctor was usually paid.

"But there is a bright side to this picture. The kindly life of a new country, and the dependence of its inhabitants upon each other, gave the doctor a strong hold upon the affection and gratitude of those among whom he lived and labored. They loved him when living and mourned for him when dead."

Charges for medical services varied. Village and country doctors were not organized and fees were not standardized. The ordinary charge in one section of the country was 25 cents a mile, "one half being deducted and the other paid in povender for his horse, or produce for his family." In the earlier years the average country doctor would probably settle for 25 to 50 cents for a local visit, or a dollar if he sat up all night.

At the end of a year's service, including care in two smallpox epidemics, an early Wisconsin doctor had received $68 in cash.

Editorial Director
DAVID N. GOLDSTEIN, M. D.

EDITORIALS

The Ubiquitous Staph

No area of the State has escaped troublesome staphylococcal hospital infections. During the past few years a tremendous store of information has been developed about these antimicrobial resistant villains, and alert medical groups have effectively joined combat.

Every hospital staff should have an Infection Committee with real authority to institute prophylactic procedures immediately upon observation for their need. For effective elimination of a potential killer there can be no prolonged committee deliberation with referral of recommendations, delays for governing board approval, executive committee consent, and the like. The seeding of multiple infants, post partum breasts, aged lungs, and postoperative incisions wait for no one.

The four articles in this issue of the *Wisconsin Medical Journal* provide a blueprint for the scope of such a committee. They are of great practical importance in pointing up the measures for eliminating and preventing this scourge of the antibiotic age.

Bacteriophage typing, now easily available, makes possible precise identification of the organism. Methods of control are for the most part dictated by common sense.

A vigilant Infection Committee will find breaks in technique and correct them on the spot. Operating room and nursery personnel will be carefully screened for carriers, infected cases will be isolated, contaminated materials and rooms will receive special treatment, regular sterility checks will be made, rules for clothing and mask changes will be strictly enforced, and a continuing educational program instituted for everyone.

Does a physician in your hospital come inside from the parking lot, walk straight into the operating room to say "hello" to his patient before the anesthetic is administered and then go to the dressing room? Does a scrub nurse wear the same mask during a whole morning of surgery on different patients? Are dressings changed on several patients successively with no hand washing or cart changes between them? Are floors wet mopped rather than swept?

Control is not difficult. Awareness and cooperation are essential; and it must be a total effort by the doctors, nurses, aides, administrators—and even hospital architects.

The Case for Certification of Psychologists

Bill 423, A. before the current Wisconsin Legislative Assembly provides for the examination and registration of psychologists. The State Medical Society of Wisconsin has opposed this bill, which has the backing of the National Association of Psychologists, principally because of doubt that the bill was in the best interest of the psychologists themselves.

Were the bill to pass as written, clinical psychologists could not practice in Wisconsin because of specific exclusion from treatment of the sick. There is evidence that similar legislation in other states has not worked well. Even the psychologists seem to be divided on the bill's merits as demonstrated during the hearing on April 16.

Edward D. Schwade, M.D. discussed the subject of certification for the psychologist in the March, 1959 *Wisconsin Medical Journal*, urging the development of voluntary methods of recognition of psychologic competence. He took exception to legislative certification because he felt there would develop a tendency, as observed in other paramedical areas, to take on additional functions properly appertaining to physicians.

The medical profession finds no comfort in opposing the highly respected, learned profession of psychology. The aim of the Wisconsin Psychological Association is the protection of the public from inadequately trained persons representing themselves as psychologists. They ask for certification and not licensure. They wish to protect the good name of psychology.

Clearly there is need for further discourse between our professions, to the end that there is the same unity in legislative effort as the time honored cooperation of physician and psychologist in service to the sick.

Samuel H. Friedman, Ph. D., states the case for the psychologist. It is recommended that Doctor Friedman's article be given careful perusal.

Certification for the Psychologist—A Rejoinder

As a psychologist I have been serving as Chairman of the Legislative Committee, Wisconsin Psychological Association. This group is sponsoring a bill before the current legislature providing for the certification and registration of psychologists.

Doctor Schwade's article represented a distinct point of view frequently expressed by psychiatrists and other physicians. In this rejoinder, I would like to challenge this point of view as well as correct what I regard as some unfortunate inaccuracies and misleading statements.

(continued on next page)

EDITORIALS (continued)

In the first place no matter how defined, psychology is in the public image both a science and a profession. It has its own code of ethics, its own internal certifying boards (in clinical, counseling, and industrial psychology), but surprisingly no concomitant legal status in this state. In those states not now having legislation covering psychologists anyone at all may hang up a shingle as a psychologist and offer his services to the public. Many unscrupulous individuals have done so to the obvious detriment of public welfare.

The 1958 directory of the American Psychological Association lists 16,644 members and fellows. Of these 2,027 are members of the Division of Clinical Psychology. Other divisions and their memberships which have occasion to provide services to the public are the following: Developmental Psychology (552), Teaching Psychology (300), Evaluation and Measurement (579), Consulting Psychology (226), Educational Psychology (492), Counseling Psychology (855), and Industrial and Business Psychology (659). It should be clear from this tally that clinical psychologists are in a minority among their own professional colleagues and are not the only psychologists affected by legislation.

As of this writing the fate of the Wisconsin certification bill is uncertain. In its arguments before the legislature, the State Medical Society has expressed its opposition to the bill, decrying the danger that it may permit clinical psychologists to encroach on the province of medicine. It should be remembered that this bill provides for the certification of all psychologists in the state working in a variety of settings: academic, industrial, school, as well as clinical. In view of psychology's widespread applicability we feel that the public deserves the right to legal protection in terms of a bill which clearly defines the qualifications of persons who hold themselves able to render psychological services.

We agree with Doctor Schwade that the strife between the two professions of psychology and psychiatry is deplorable. Since committees of the two national organizations are continuing to meet, we have hope that many of the misunderstandings will be ironed out. This article represents a small local attempt to clarify some of the nagging issues.

What then accounts for the opposition of medical and psychiatric groups to legislation for psychologists? In our opinion it is in part due to the misunderstanding that these bills are solely for the benefit of clinical psychologists. Secondly, we feel the medical profession is displaying unwarranted caution in regard to its acceptance of a learned profession which already has an honorable history. We recognize that medicine has for many years had to fight off the encroachments of cultists as well as outright groups of charlatans. In this fight medicine has done an outstanding job of protecting the public interest; in its relations with psychology we feel they are reacting to a spurious threat. A third reason for medical opposition is succinctly put by Doctor Schwade: "We feel that the clinical psychologist is not qualified in the area of psychotherapy since this is a distinct medical problem." As psychologists we feel that no profession has a unique prerogative to function in this area. For one thing, as broadly defined psychotherapy is daily being performed by teachers, ministers, lawyers, in fact by almost everyone who does things for people. As narrowly defined the term loses meaning in view of the innumerable systems and approaches to psychotherapy currently employed. There is further the knowledge that the Michigan Attorney General as well as the Counsel for the New York State Board of Education have ruled that psychotherapy does not fall exclusively within the medical domain.

Clinical psychologists are ethically beholden to perform psychotherapy only under conditions of genuine collaboration with a psychiatrist or a psychiatrically oriented physician. We do not feel that the public has anything to fear from the professionally qualified psychologist, and we are likewise anxious to have physicians share in this perception because of their obvious large stake in the matter. It has been our experience that many physicians desiring to obtain the services of a psychologist seem at a loss to determine his qualifications. There have also been several unfortunate incidents regarding employment of questionable professional help by physicians who should know better. In either case the existence of a legal registry of qualified psychologists should act as a boon to Wisconsin physicians and provide them with resource of professionally trained people able to serve the public in a capable, ethical manner.

We cannot stress too strongly our dual role as a science and a profession. Just as we need trained researchers and teachers of psychology to continue opening avenues of scientific knowledge, we need skilled professional psychologists to make application of the ever growing body of techniques and processes designed to advance human welfare. As psychologists we feel that we are best able to police ourselves but we need statutory enforcement to protect the public from those malpractitioners who would usurp our title.

Doctor Schwade as a former member of the American Psychological Association* is certainly aware of many of the issues raised in this editorial. We consider it unfortunate that he has reacted so strongly to the current interprofessional strife and has not endeavored to take the long point of view. Society needs the help of both psychiatrists and psychologists, each with their own unique training, to assist people in this age of stress. Fifteen states already possess workable legislation for pychologists; we hope that Wisconsin will not lag behind in its enactment of a certification bill. In our attempt to secure such a bill we ask for the help of the Wisconsin medical profession.—SAMUEL H. FRIEDMAN, PH.D.

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* Editor's Note: Doctor Schwade resigned several years ago.

THE MEDICAL FORUM

STATE AFFAIRS

VA

New Home Town Care Rules

Since 1946 the SMS has had a contract with the Veterans Administration to operate the Home Town Care Program for veterans.

The contract has been renegotiated each year, but there has been a continuous withdrawal by the VA of SMS administrative functions.

Effective July 1, 1959 the VA will handle all the administrative work. The new rules include the following:

¶ If a veteran requests treatment for a service-connected disability, notify the VA office, 342 N. Water St., Milwaukee, either by letter or by VA-provided form.

¶ If the veteran is eligible, the VA will send the physician the proper forms. If treatment is on a long term basis, the VA will issue a long term authority. This procedure will save on paperwork and tend to avoid some past inflexibilities.

¶ *The physician will send his bill at the end of each month directly to the VA, using its forms.*

¶ A report on medical findings is to be made to the VA each 90 days. The VA will send the report forms when due.

¶ Use the veteran's name and claim number on all forms: authorizations, bills, medical findings, etc.

¶ The VA will pay each physician directly.

¶ The SMS will continue to negotiate a fee schedule with the VA on a state-wide basis, will continue to aid physicians who want to participate in the program. There appears to be a safeguard in this "list of participating physicians" which will guarantee the veteran a free choice of physicians.

¶ The SMS will also establish one or more advisory committees to counsel, assist and recommend improvements in the program.

¶ The SMS, upon request of a local physician, agrees to review any case rejected by the VA.

¶ The new fee schedule, in effect on July 1, 1959, negotiated between the VA and SMS, will be sent each physician.

Ambulance Service

In medical emergencies the VA will pay for ambulance service or other transportation of patients to its hospitals when prior authorization has been granted.

Physicians may obtain authority by telephoning the VA hospital. Eligible for such transportation: veterans with service-connected conditions and those with nonservice-connected ailments who can't afford transportation costs.

MENTAL ILLNESS

Speakers Available

County medical society program chairmen can now call for speakers on mental retardation.

The SMS Foundation, as reported previously, has received a grant of $500 from the Wisconsin Council for Mentally Retarded Children.

The grant provides for postgraduate educational programs, utilizing physician speakers, throughout the state. Speakers are available without cost.

In making the grant, Frank N. Schneider, Executive Director of the Wisconsin Council, announced the appointment of Dr. E. D. Schwade, Milwaukee, to head a professional advisory board to provide medical guidance for the Council.

CHIROPRACTIC

New Twist

A recent Wisconsin Supreme Court opinion apparently uncovered a loop-hole in the law: in the absence of a statutory definition, the chiropractic board of examiners could define chiropractic as it sees fit.

The board moved quickly, expanding chiropractic practice with three new rules, effective June 1:

1. A chiropractor may supply "dietary advice, and supplementary foods in the original container. . . for the purpose of providing special dietary needs and improving nutritional balance, but such foods may not be prescribed as treatment for specific diseases."

2. "A chiropractor may employ a technician to operate an X-ray machine only upon furnishing proof satisfactory to the board that such technician has successfully completed a course of instruction approved by the board. Such work may be done only under the general supervision and direction of a licensed chiropractor."

3. At the same time the board ruled that the practice of chiropractic regularly in living quarters (bedside care excepted) as well as the maintenance of an unsanitary office or equipment shall be considered "unprofessional conduct".

NARCOTIC LAW

Every physician who distributes, dispenses, gives away, or administers narcotic drugs to patients must register and pay a tax of $1.00 on or before *JULY 1.*

A physician who first engages in such activities must immediately make a similar registration. A physician having two offices must register for both. Each office must have a separate registration number.

Register with the Secretry of the Wisconsin State Board of Medical Examiners, Room 1140, State Office Building, 1 West Wilson Street, Madison 3, on a form which is furnished by the Board of Medical Examiners.

You are subject to penalties for overlooking either the registration or the tax. Registration is usually done in January.

STATE AFFAIRS

WPS

Legislation

For the past 20 years the SMS has endorsed the idea of "reasonable but realistic state insurance department supervision of Blue Cross and Blue Shield plans".

Just weeks ago another official statement on the matter was released to the press.

Early this month Gov. Gaylord A. Nelson had a bill introduced in the Assembly to provide stricter regulation of the three nonprofit plans (Blue Cross, Blue Shield including WPS, and Surgical Care).

"The insurance department does not have adequate authority to protect the 1,100,000 Wisconsin residents covered by these plans," said Nelson.

But he stated that "the regulations do not in any way imply present abuses, but are proposed because I feel this is an area where the public interest requires the state government to act as overseer."

The Governor said his bill would not control rates.

POISON CONTROL

Henceforth, each issue of the Medical Forum will carry a box on poison control centers located throughout the state.

In addition, this issue of the *Wisconsin Medical Journal* carries an insert opposite page 62. This tear-sheet, for doctors and hospitals, is a hospital emergency procedure for poison cases. Additional copies are available upon request to the editor.

Madison

ALpine 6–6811, University Hospitals Poison Information Center, Madison.

Milwaukee

DIvision 4–7100, Poison Control Center, Children's Hospital, Milwaukee

Kenosha

OLympic 4–5311, Poison Information Center, Kenosha Hospital, Kenosha.

APPOINTMENTS

National Institutes of Health

Dr. Carl N. Neupert, State Health Officer, announced the appointment of Dr. Milton Feig, Director of the Section on Preventable Diseases, as special consultant to the Division on Research Grants in Accident Prevention, National Institutes of Health.

Dr. Feig's duties will consist of reviewing and recommending action on applications made to the National Institutes for research funds in accident prevention.

DR. MILTON FEIG
A consultant . . .

SAFETY

Traffic Stamp Resolution

The SMS proposal for a commemorative traffic safety stamp, to be issued by the U. S. Postmaster General, gained strength from the Wisconsin legislature.

Both houses passed joint resolution 42,S, calling for the postage stamp "during the next 5 years in an effort to stimulate in the motorists an awareness of the need for improved driving habits by the American people. . ."

Copies of the resolution will be sent to Postmaster General A. E. Summerfield and members of the Wisconsin Congressional delegation.

As the *Medical Forum* went to press word came that the AMA, meeting at Atlantic City, has endorsed the SMS traffic safety stamp proposal, will assist in getting it officially accepted by the Postmaster General.

WPS

New Rates

Beginning July 1, WPS will raise its health insurance rates on certain non-group and "conversion" (those leaving an insured group) contracts.

Rate changes will affect less than one-fourth of the 103,000 WPS contracts.

The increases were placed in effect because claims paid were exceeding premiums received in most non-group categories. This problem exists not only in Wisconsin but nationally.

Said Herman L. Toser, WPS insurance director: "The increased claims paid by WPS to doctors and hospitals indicates that the people of Wisconsin are taking better care of their health than ever before."

To keep the non-group insurance programs on a sound basis, WPS had two choices: increase rates or reduce benefits. WPS decided to increase rates to continue the benefit program which has proved so effective and popular.

For certain subscribers age 65 and over, the Century Plan contract will be substituted for previous benefits to correct the problem of excessive utilization.

The new increases range from $.55 a month for single medical–surgical–hospital non-group contracts to $1.78 for similar family contracts. New rates are $2.40 a month for the former and $12.24 for the latter.

NATUROPATHY

Legislation

Recently in Missouri, the Supreme Court closed up a naturopath's Kansas City clinic, calling it a "public nuisance. . ."

Recently in Wisconsin, legislature considered bill 416,A which would permit naturopaths to practice here. It was backed by about a dozen individuals who allegedly practice the forbidden method.

There was some legislative support as well, with the retort that "a doctor is best at diagnosing the size of a patient's wallet. . ."

But late last month good sense prevailed: 416,A, which would permit a public nuisance, was killed.

STATE AFFAIRS

CLARK COUNTY

Diabetic Clinic

The Memorial Hospital, Neillsville, has announced that a diabetic diet clinic is being organized for all interested individuals in the community.

The program will be under the direction of the hospital medical staff and a registered dietician and will be open to all diabetics, friends or relatives who prepare the food.

The institute will center primarily on diet problems with emphasis on how to make the special diets more interesting and palatable.

ELECTIONS

Public Health

Dr. Charles K. Kincaid, Madison's city health officer, was unanimously elected to succeed himself as president of the Wisconsin Association for Public Health last month.

Over 300 persons attended the organization's annual meeting at Green Lake. Delegates also unanimously re-elected Paul Weis, Assistant State Registrar, State Board of Health, as secretary–treasurer. Miss Ruth Telinde, Executive Director, Madison Visiting Nurse Service, was named the new vice-president. Also elected were two new directors: Karl Mohr, Green Bay city sanitarian, and Betty Kripene, State Board of Health Dental hygienist, Fond du Lac.

The two-day event featured an address by Dr. W. W. Bauer, (formerly of Milwaukee and Racine) Director of the Bureau of Health Education, AMA.

COUNCIL

Oath of Office

For some time it had been the thinking of many SMS members that a dignified, formal ceremony was needed for the installation of new officers.

The House approved of the idea, and the Council will devise an oath of office to be administered through its Chairman with appropriate ceremony to each constitutional officer and each Councilor.

SHEBOYGAN

Immunization

The Sheboygan County Medical Society has begun an educational program to encourage more adequate immunization throughout the area. The emphasis is on tetanus and polio.

Society physicians are doing all the planning of the educational program with the Sheboygan County Welfare Council, which includes representatives of nearly 80 voluntary health, welfare and civic groups.

DR. CHARLES K. KINCAID
. . . and a president

EXAMINATIONS

State Boards

The written examinations for the State Board will be held at the July meeting in Milwaukee on the 14th, 15th and 16th. The reciprocity examinations will be held on July 15 only in Milwaukee, according to the State Board of Medical Examiners.

TELEVISION

Medical Films

A report indicates that Wisconsin television stations are making pretty good use of medical films provided by the AMA.

In the last two years, said the AMA, 79 films have been beamed over state stations, an average of slightly over three a month.

FOND DU LAC

Intensive Patient Care

Under study at Fond du Lac's St. Agnes hospital is the new concept of intensive patient care.

An "Intensive Care Unit", calling for specialized nursing of certain patients 24 hours a day, has been in operation for the last six months.

St. Agnes is the first hospital in this part of the state and one of the first in Wisconsin to initiate such a program. Only within the last year has this type of care been utilized in general hospitals.

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STATE AFFAIRS

LETTER TO THE EDITOR

News Item:

TOO MANY 'SURGEONS' UNTRAINED—SURGEON

New York (AP)—Dr. Paul R. Hawley, director of the American College of Surgeons, says it is reliably estimated that one half of the surgical operations in the United States are now performed by "doctors who are untrained, or inadequately trained, to undertake surgery.

He says inadequately trained physicians are doing an increasing amount of surgery because every insured patient is a paying patient.

Hawley made the statements at a session of the Group Health Institute Wednesday.

He said one of the world's most distinguished surgeons told him that at least half his practice now "consists of attempts to correct the bad results of surgery undertaken in community hospitals by doctors inadequately trained in this field." He did not name the surgeon.

Hawley said the existing plans combining prepayment with group medical practice provide medical care of high quality.

He said, however, that nationwide extension of such plans could be dangerous "unless equal high quality of care could be assured."

Hawley said the success of the plans now existing is due to their ability to select the physicians who give the medical care.

Rebuttal:

THROW HAWLEY OUT

Again Dr. Paul R. Hawley, Director of the American College of Surgeons hits the news.

This time the martyr cries to the public that poor surgery is being performed in small community hospitals. He also suggests that surgery is being done because the patient is medically insured.

Dr. Hawley suggests, also, that good surgery could be assured the public by large group practice type of medicine financed by insurance.

Some of the best trained surgeons in Wisconsin are in practice alone or in small partnerships. Some of these surgeons even practice in small communities.

Leaders of our AMA have repeatedly warned us of the dangers of third party control of medicine. Dr. Hawley, apparently, has his own ideas about this.

The basis of his recent medical slander is the talk of one single surgeon.

How long are the surgeons of Wisconsin going to let this "old record" play its Out-Of-Tune melody?

Surgeons of Wisconsin: there is only one way to stop this . . . Throw Hawley Out Of His Office.

LOU R. SCHMIDT, M. D.
La Crosse

SPECIALTY SOCIETIES

Academy of General Practice

In a continuing effort to keep educational standards at a high level, the Wisconsin Academy of General Practice, dropped eleven members for failure to perform their postgraduate education requirements.

Membership in the Academy is based on the ability of members to attend at least 150 hours every three years of some form of postgraduate education. The GP Academy is the only specialty which requires its members to continue studies after formal schooling.

APPOINTMENTS

State Boards

Gov. Gaylord A. Nelson announced the appointments recently of the following to various state boards:

State Board of Health:
Dr. Edward N. Vig, Viroqua
State Board of Nursing:
Dr. Howard V. Sandin, Ashland
Basic Science Board:
Prof. John W. Saunders, Jr., Marquette University.

HOSPITALS

SMS Awards

Three Wisconsin hospitals will be selected annually to receive "community hospital service" awards from the State Medical Society, it was announced by Dr. William B. Hildebrand, president.

The awards will be given each year during National Hospital Week, starting in 1960. The recipients will be small, medium sized and large hospitals which have demonstrated achievement in improved facilities, service or expansion of their overall usefulness to the community.

"Community hospitals receive all too little credit for the remarkable service they provide to the sick and injured and to the entire community," Dr. Hildebrand declared.

"In the last decade," he said, "nearly 200 new or remodeled hospitals have added 6,069 new hospital beds at a cost of $100,000,000. About 120 of these hospitals were built in rural areas."

"During this week of recognition for hospitals, May 10–16, the public should join physicians in taking their hats off to the progress of our Wisconsin hospitals," Dr. Hildebrand urged. "It takes a lot of heart along with the brick and beds to provide adequate hospital care—and Wisconsin has plenty of both."

U.S. GOVERNMENT

Hill–Burton Grants

A recent report from the Department of Health, Education and Welfare contains the status of all

Hill-Burton grants made in Wisconsin.

During the month of February, said HEW, three projects were approved:

¶ $228,800 grant to a total project cost of $4,843,750 for St. Francis Hospital, La Crosse.

¶ $42,000 grant to a total project cost of $105,000 for Ladd Memorial Hospital, Osceola (includes 11 extra beds).

¶ $240,000 grant to a total project cost of $600,000 for St. Mary's Hospital, Wausau, (includes 54 extra beds).

To date, 48 Hill-Burton projects have been completed and are in operation in Wisconsin. Total cost: $38,583,345, with a federal share of $12,514,007; total additional beds: 1995.

Still under construction: 37 projects with a total cost of $30,714,465 and a federal share of $10,330,844, adding 1,003 beds.

Approved, but not yet under construction (including February's grants): 8 projects with a total cost of $9,571,250 and a federal share of $1,869,806, adding 208 beds.

AGING

Conferences

With the White House Conference on the Aging set for January, 1961, preparations have moved into high gear.

Dr. A. M. Hutter, Fond du Lac, is SMS representative to the first joint conference for the improvement of the care of the aged in Washington, D. C., June 12–14 and the White House planning conference at Ann Arbor, Mich., June 24–26.

Miss S. Janice Kee, State Library Commission, as chairman of the State's Interdepartmental Committee on the Aging, is in charge of planning another Governor's Conference for the summer of 1960.

INVENTIONS

Night Light

A transclucent telephone which lights up when a call is received has been designed especially for use by doctors, hospitals, ambulance stations, and others who frequently have to take calls at night.

URGENT NOTICE

American Medical Association recommends that the following steps be taken in the poliomyelitis inoculation program:

(1) Each physician assumes the responsibility for making certain whenever possible that all members of families he serves receive protection against poliomyelitis by having the full three doses of polio vaccine:

(2) State medical organizations arrange with state health departments for a joint effort to bring together county medical society representatives and representatives of county and city health departments for the purpose of discussing the need for joint study committees at the local level to survey the problems which may exist and to work jointly to solve them;

(3) County medical societies meet with county and local health department representatives to create study committees to survey the problem of immunization as it may exist in the local area and develop and implement a satisfactory program to meet the local situation.

A ROPE "LOOPHOLE" was presented to Robert Murphy (center), SMS legal council, at a recent joint dinner meeting of the Green County Medical Society and the Green County Bar Association. Flanking Murphy are Drs. L. G. Kindschi (right) and R. G. Zach, both of Monroe. The rope was jokingly presented to indicate the supposed "flaw in the law" which some attorneys allegedly seek to win their point.

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MEDICAL WORLD

LAW

M.D.'s To Rescue

One of the plaguing things about obtaining justice in a court of law is that judicial dockets over the country are jammed; sometimes years behind.

According to a report from the American Judicature Society, physicians in two cities are now coming to the rescue by providing a method toward quick settlement in personal injury cases.

Both New York City and Baltimore courts are experimenting with the use of impartial medical experts.

In New York, the judge can call on experts from panels appointed by local medical societies to resolve conflicts between parties.

A doctor examines the patient and all medical records, then reports to the court.

During the first two years, half the cases using the medical panelists resulted in settlements, thus speeding court processes.

In Baltimore, a panel is also named by the local medical society. The opposing lawyers agree upon a doctor and usually the litigants pay his services.

CONGRESS

Research Funds

The federal National Institutes of Health, which supports medical research, training and construction, came into Congress recently with a 1960 budget proposal that was up 14½% ($344 million) over last year.

Such a proposal demanded an explanation, and Congressman Melvin R. Laird (Rep., Marshfield) was ready with it.

REP. MELVIN R. LAIRD
Ready with an explanation.

Laird, who serves on the House Committee which had approved the budget, said: "The funds spent on medical research will return greater dividends to our people than the vast appropriations made for missiles, space and other research."

"We can insure the maximum in medical progress," he went on, "we can make our position secure as the world leader in medical research, if we continue to provide the necessary means for maintenance and growth of America's most essential scientific endeavor—the conquest of disease."

"My State, I am proud to say, is a leader in medical and other fields of research. To mention one example . . . the discoveries that led to the life-saving drugs that prevent and help control blood clotting came from Wisconsin research. . ."

"In addition, Wisconsin people recognize that research is a necessary step toward practical achievement, and our statesmen as well as our scientists have long been known for leadership in the growth and development of research. . ."

Laird's final point: "The investment is small compared to the potential economic benefits which will come as medical research achieves new knowledge to bring the killing and crippling diseases of today progressively under control.

UNITED STATES SENATE

May 25, 1959

Dear Mr. Crownhart:

I deeply appreciate receiving your letter of May 5th, signed by Petitioner Delegates of the Wisconsin State Medical Society, with reference to H. R. 10, the Keogh–Simpson Bill.

Over the years, I have felt that encouragement and cpportunity should be provided the individually self-employed to lay away funds for their own retirement. This is particularly important since, for the most part, other retirement plans are not open to many of the folks in this category.

As you are aware, the Treasury Department—because of a $12 billion current deficit and a "tight" budget for 1960—is opposing legislation, including H. R. 10, which would reduce revenue.

It is expected, of course, as you point out, that a substantial proportion of these taxes would be regained in later years when the retiree would pay taxes on retirement benefits.

Naturally, the Congress must weigh these factors in considering this proposal during the current Session of Congress.

Appreciating the merits of the objectives of this bill, I shall be happy to urge my colleagues serving on that Committee to act expeditiously on this legislation.

Again, with appreciation for your views, and with all good wishes, I am

Sincerely,
(signed) ALEXANDER WILEY

EDUCATION

Tomorrow's Doctors?

Looking glumly at the future, Dr. John A. D. Cooper, assistant dean of Northwestern's medical school, recently stated that tomorrow's doctors are finding other careers.

According to the press reports, Dr. Cooper blamed part of the situation on the ability of other professions to offer greater inducements for fellowships and research assistantships.

"Medicine," he said, "has no equivalent source of subsidy for its students."

To correct the matter Dr. Cooper urged steps to shorten the medical program and grant higher professional and economic status to the physician in specialty training.

ADOPTION: *Physician's Part*

All the helping professions are interested in adoption. Some are concerned because they work with families who have an adopted child or wish to secure one; others because they contribute first hand to the placement of children for adoption. Some professional people— physicians, social workers, lawyers— have a unique part to play in establishing a happy family for a child who needs a home and new parents through adoption.

Every mother who gives her child for adoption, every child who is adopted—and every couple who adopts a child—requires medical, legal, and social services. Any one service without the other exposes the people involved to the tragedies and heartbreak growing out of hasty decisions to give up or to adopt a child, placement of children in unhappy homes, unstable adoptions resulting from lack of preparation of the mother, child or adoptive couple, or removal of children from families that have loved and cared for them.

A child legally becomes a member of another family through adoption. Before judicial action and decree in adoption occur, a decision must be made as to whether or not permanent separation meets the best interests of the natural parents and child. While termination of parental rights is a matter requiring court action, medical, legal and social services should be available in reaching such a decision. ***Once this decision is made, the focus is on finding a family for a child rather than a child for a family.***

In most States the State department of public welfare has responsibility by law for licensing, standard setting, and supervision of adoption and foster care services by public and voluntary agencies. *Placement of a child by an intermediary, with or without payment, is illegal in most States.*

Adoption services have been expanded in many parts of the country. In some sections adoption practices reflect the belief that almost any child needing a permanent home can be adopted. More unmarried mothers are receiving the social service so essential to their future well-being. Agencies recognize that many prospective adoptive applicants are willing to take risks on certain "unknowns" about infants. More young infants are being placed for adoption. In almost every State, agencies are searching for suitable homes for older children, those with handicaps, and those of minority or mixed races. In many instances physicians are contributing their knowledge and understanding to these advancements.

THE PHYSICIAN'S RESPONSIBILITIES

Physicians have both direct and indirect responsibilities in adoption to patients, to health and welfare agencies, and to society. These responsibilities revolve around service to any or all parties involved in adoption, as well as to the community.

Direct Responsibilities

The physician is directly responsible for medical service to the natural mother, the child, and the prospective adoptive couple and for referring them to the appropriate social agency. Physicians should not place babies in adoptive homes. Social agencies are better equipped and in most States have the legal responsibility for doing this, but these agencies depend on physicians for medical judgment in placing children. The rapport between the physician and his patient affects the psychological readiness of the individuals referred for help.

For the natural mother whose first confidant is often the physician, he provides maternity care including prepartal, hospital confinement, and post-partal care, and medical care for other conditions requiring treatment. He refers the unmarried mother to a social agency for help with emotional, social, financial, or environmental problems.

The physician to whom the girl first goes may render all the medical services or he may arrange to have some provided by others. His choice depends upon his specialty, resources in the community, agreements on provision and payment for service or some personal reason. As far as possible, he respects her desire for anonymity and confidentiality. In some situations, as when an unmarried pregnant girl is a very young minor, the physician may be required to reveal identity of the patient to her parents or to certain authorized individuals or agencies.

THE PHYSICIAN'S PART IN ADOPTION*

For a number of years, the Children's Bureau has been studying ways of offering maximum protections to children considered for adoption, their natural and adoptive parents. In June, 1955, the Bureau, deeply concerned with these problems, sponsored a meeting of representatives of national organizations in the medical, nursing, legal, religious, and social welfare fields to explore ways of eliminating "black market" placements and unauthorized adoptions.

One outcome of that meeting was a recommendation that the Bureau work with the various professions, especially social work, medicine and law, in examining the individual and joint roles of the social worker, the physician, and the lawyer in adoption. To this end, the Bureau planned separate meetings of these three groups.

In November 1957 a group of physicians came together to consider the role of the physician in adoption. The group included general practitioners, public health and hospital administrators and specialists in obstetrics, pediatrics, psychiatry and internal medicine. These 17 physicians discussed the place of their profession in adoption, in relation to natural parents, usually the unmarried mother, to the child and to adoptive parents.

This article deals with the part the physician plays in adoption. The word "physician" is used to cover the multiple services provided by the medical profession in adoption and assumed by many physicians such as those represented in this group.

* Reprinted by permission of the Children's Bureau, U. S. Department of Health, Education and Welfare.

Adoption:

As early as possible he refers the mother to an appropriate social agency in or near the community. In the absence of such a local agency, he gets in touch with the State department of welfare. Some of the problems with which the social agency can help are: "Where can I live?" "How can I face my parents?" "Who will take care of me?" "What will I do with my baby?" The social worker gives counseling and psychological support that help the mother with her fears and anxieties. The agency often provides financial assistance and plans living arrangements for the mother, helps her secure legal advice and make plans for her baby.

For the child whose good start in life depends on the physician, he provides or arranges for periodic diagnostic appraisal and continuous medical supervision. The physician's appraisal of the child is one of the key services in the adoption process.

Adequate medical appraisal of the child before and after adoptive placement is essential.

For the couple who turns to the physician for his advice and help in adopting a child, the physician is responsible for medical service and for determining whether the couple has reasonably good health and life expectancy. He refers the couple to a legally authorized adoption agency to help them gain more insight into adoption.

He sees that they get an adequate fertility assessment, including interpretation of findings by referral to a specialist if this is beyond his competence. Social workers have special training in interviewing techniques and skill in helping people who are considering taking a child for adoption. They can help the couple decide whether or not they want to or should adopt a child and assist them in following through with an appropriate plan.

Indirect Responsibilities

Certain responsibilities of the physician, though indirect, are equally important. They grow out of the physician's relationships with other professions, agencies, or individuals and out of his responsibilities as a citizen.

As a consultant to a social agency, the physician interprets the physical condition of the child to the agency and makes recommendations as to his adoptability on the basis of an evaluation of the medical background, the child's health, or, for the handicapped, his special needs, and the prognosis for healthy growth and development. He also acts in a consultative capacity in relation to the medical suitability of a prospective adoptive couple. The physician develops criteria on adoptability from a medical standpoint for use by the agency. He also contributes to the agency's staff development program.

As a hospital staff member, the physician helps to develop medical staff policies that insure adequate medical and social care for the unmarried mother and her child. His responsibility as a staff member includes not only good medical care to his individual patients but education of his fellow staff members to the need for complete medical and social care for every unmarried mother and her baby, in accordance with State laws and accepted good social practices. Good medical care also includes the maintenance of accurate medical records; he is responsible for an accurate reporting of births for birth registration.

Physician's Part

He assists hospital administrators in developing sound policies for staff members which will prevent their participation in the independent placement of a child. He works to make hospital policies accord with laws of the State relating to placement of children, licensing, termination of parental rights, adoption, guardianship, children born out of wedlock. Physicians and those responsible for the administration of the hospital try to develop policies that not only meet legal requirements but go beyond these in offering maximum proection.

As an educator, the physician helps to build the understanding of medical and health personnel as to the great impact of adoption on our society, its magnitude and importance, its problems and hazards. He works with other professional groups in this way, too—such as students and faculties in schools of social work, nursing, law.

Since the physician cooperates with many individuals within the medical and health field such as medical students, members of medical societies, nurses and students of nursing, administrators, and other personnel in hospitals and public health agencies, he has many opportunities to contribute to the development of sound practices in adoption. He may work through committees or through discussion groups around selected cases at meetings of city, county, State or national medical societies. He encourages medical schools to include adoption content in the curriculum of such specialties such as pediatrics, obstetrics, psychiatry, and public health. He may produce articles for newsletters in various medical journals.

The physician, if he is to do a good educational job, will want to keep abreast of developments, new knowledge and changes in adoption practice. In doing this, he builds up a good file of literature for his own use and that of other people including material on agency resources, policies and procedures, and State laws. State departments of health and welfare are good sources for this information.

As a citizen, the physician takes an active role in community activities relating to planning for adoption services. He may work with people in mass communications—newspapers, magazines, TV, and radio to help educate the public on the interrelationships among the various professions in providing protections needed in adoption. He may urge and support research and community surveys on various aspects of adoption.

He can serve as a member of a board or committee of a public or voluntary social agency. By serving on citizens adoption committees, the physician can help to make known the needs of children and of natural and adoptive parents.

He can work with medical societies, other groups and individuals for legislation to prohibit unauthorized placement of children for adoption and other sound legislative measures related to it. Through participation on panels concerned with adoption and joint discussion with clergymen, attorneys, social workers, and citizens he can contribute to better community understanding of adoption. The physician may help in identifying and filling gaps in service and in planning studies on the availability of medical care to unmarried mothers, or planning for dependent children.

The physician has a vital and important role in adoption. His medical competence and judgment are fundamental to a sound adoption program. But he can make his contribution only in conjunction with other professions. When all helping professions collaborate, adoption can realize its promise of happy family living for the child who must have new parents.

THE WISCONSIN MEDICAL JOURNAL

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Paroxysmal Nocturnal Hemoglobinuria: A Case Report

By ROBERT E. URBANEK, M. D., KENNETH VOGEL, B. S., and WILLIAM G. RICHARDS, M. D.

Beaver Dam, Wisconsin

PAROXYSMAL NOCTURNAL hemoglobinuria, or PNH, was first described in 1882 by Paul Strübing[1] when he accurately outlined the essential clinical symptoms and signs. Little further progress was made until the middle of the 1930's when under Donati's eponym of the Marchiafava[2]–Micheli[3] syndrome, several studies were made of the hemolytic mechanism. The hemolytic mechanism is now known, but little has been accomplished in the treatment of the disease. Crosby[4-10] has done much to clear the way toward a better understanding of the pathologic mechanism behind the disease.

Case Report

Mrs. E. K. was a 49-year-old white female who was first seen because of signs of anemia in May of 1955. She was admitted to the hospital complaining of dizziness, weakness and dyspnea on exertion. Her red blood count was 1,300,000/cu. mm.; hemoglobin 5.0 gm.% and white blood count 3,000/cu. mm. She received six transfusions of whole blood and was discharged with 12.1 gm.% of hemoglobin and 4,120,000/cu. mm. red blood cells. No definitive diagnosis was made. In reviewing her past history it was noted that she had had dark, amber and turbid urine in March 1954 when she was admitted for a tonsillectomy.

In December of 1955 she was referred to the University Hospitals at Madison, Wisconsin, where a diagnosis of paroxysmal nocturnal hemoglobinuria was made. She was advised to have blood transfusions whenever necessary but to limit her intake of hematinic preparations either parenterally or orally to prevent exacerbations of the hemoglobinuria.

In October 1956, she was readmitted with weakness and anemia. Her red blood count was 1,280,000/cu. mm., white blood count 2,950/cu. mm. and hemoglobin 4.4 gm.% There were 43 nucleated red blood cells per 1,000 white blood cells. She received 4 whole blood transfusions and was discharged with a hemoglobin of 10 gm.%.

She had an occasional blood transfusion during the next year and in January 1958 she was admitted once again for pronounced anemia. She had a striking pallor and a grade one systolic apical murmur, but was otherwise normal on physical examination. A cytology smear of the cervix was normal and the pelvic examination was negative. A complete x-ray study of the gastrointestinal tract including barium enema was normal and the gallbladder visualized well. An electrocardiogram was normal. Bleeding time was 13 minutes, coagulation time 6½ minutes, total bilirubin 1.8 mg.%, direct bilirubin 0.18 mg.%, indirect bilirubin 1.62 mg.%, hemoglobin 3.9 gm.%. She received 3 whole blood transfusions and had fever from 101 F. to 105 F. She was discharged with a hemoglobin of 9.7 gm.%.

In late February she was readmitted with 7.1 gm.% hemoglobin and a 2,300/cu. mm. white blood count. She received 4 transfusions with febrile reactions ranging from 102.6 F. to 104.8 F. The use of antihistaminics and steroid compounds had no effect on the transfusions' reactions. At this time she was placed on anticoagulant therapy and

her prothrombin time brought down to 14.5% of normal.

On March 4, 1958, she entered the hospital with a superficial thrombophlebitis in the right thigh. This area became indurated and finally broke down to form a deep abscess in spite of the fact that her prothrombin time was 23% of normal. Her hemoglobin was 7.5 gm.% and her platelet count 60,000/cu. mm. She began receiving saline-washed red blood cells, but because of the fever from the abscess, febrile reactions were difficult to evaluate. At discharge her hemoglobin was 8.6 gm.%. The ulceration of the thigh gradually healed with home care. During these past few admissions it was noted that the morning urine was darkest and a test for hemosiderin in the urine was positive. The major hemolysis appeared to be taking place during the patient's sleeping hours.

In April 1958, she again received several transfusions with febrile reactions to 104.6 F. She began receiving "buffy poor blood" toward the end of April and the febrile reactions were considerably less. She had one episode of acute cardiac decompensation after transfusion, but this responded quickly to therapy. Her hemoglobin rose from 4 gm.% to 11 gm.% with these transfusions.

Her final admission was in May 1958. Her prothrombin time was 10.7% of normal and the hemoglobin was 4.2 gm.%. She had 12 units of 500 cc. each of buffy poor blood since April 1958, with only mild transfusion reactions. The patient was extremely ill on this admission with numerous areas of ecchymosis and petechiae over her body and bleeding fissures at the corners of her mouth. Administration of buffy poor blood raised her hemoglobin to 8 gm.%, but she gradually became comatose and on May 27, 1958, she expired.

Autopsy Findings

The skin was very pale and showed numerous petechiae and ecchymotic areas. Subcutaneous hematomas were noted in the left deltoid region and the right buttock. The liver and spleen were both enlarged on palpation of the abdomen. Fluid was present in the abdominal cavity, pleural cavities and pericardial cavity. The heart weighed 360 gm. and showed subendocardial hemorrhages and focal areas of myocardial fibrosis. The lungs were markedly edematous. The liver weighed 3,000 gm. and the spleen weighed 360 gm. They were both congested. The kidneys were anemic in appearance and blood was present in the pelves and ureters. The gastrointestinal tract was filled with partially digested blood. The gross findings were substantiated on microscopic examination. The focal areas of myocardial fibrosis were attributed to anemic infarctions of the myocardium. There was some hemosiderosis in the spleen. In the kidneys the proximal and distal convoluted tubules and the loops of Henle contained numerous yellowish-brown pigment granules within the cytoplasms of their lining cells. The collecting tubules were spared and the glomeruli were normal.

Pathologic Physiology

Paroxysmal nocturnal hemoglobinuria is a chronic, often self limited disease marked by exacerbations and remissions of intravascular hemolysis with hemoglobin presenting itself in the urine. The hemolysis takes place during sleep regardless of the time of day. When the hemoglobinemia produced by the hemolysis of red blood cells exceeds approximately 130 mg.% hemoglobinuria results. The main defect is thought to be an intracorpuscular one and appears to be in the stroma of the red blood cell. With the aid of the electron microscope the stroma was compared to the normal cell. The PNH red blood cell shows a morphologic abnormality consisting of a patchy appearance with many clefts as if a coarse precipitation had taken place indicating a particular membrane fragility.[11, 13] Crosby has suggested that this defect is in an enzyme system which preserves and renews the stroma.[7] Harris, *et al.*[14] have suggested an abnormality of the phospholipids. Munn, *et al.*[15] have investigated the extra surface of the macrocytic PNH cells and have shown the lipid pattern of the lipoproteins to be abnormal. Whatever the exact nature of the defect in the red blood cells may be, it renders these cells more susceptible to hemolysis than the normal red blood cells even in the presence of a normal mechanical fragility.

The hemolytic mechanism acting on the susceptible PNH cell is present in normal plasma and is known as the properdin system. Properdin is a serum euglobin which is not in itself lytic to PNH cells, but in the presence of complement and the magnesium ion, at an optimal pH of 6.9 to 7.0, will lyse these abnormal red blood cells. A heat stable inhibitor and a heat labile inhibitor act upon this system. There are also corresponding

heat labile and heat stable accelerators present. Some people believe that all formed factors of the blood are involved, with increased susceptibility to infections explained as due to leukopenia. Thrombosis is attributed to a proneness of the platelets to agglutinate in spite of the thrombocytopenia.

At autopsy the outstanding feature of the disease is the tendency of hemosiderin to accumulate mainly in the proximal and distal convoluted tubules and the ascending loops of Henle. There is reason to believe that the renal threshold drops as the tubules become more and more saturated with hemoglobin products. Hemosiderosis may be seen in the spleen, liver, pancreas, and other organs in cases of multiple transfusions. Grossly the kidneys are enlarged with conspicuous brownish-red cortices. The bone marrow shows a normoblastic hyperplasia[7,16] with a variable shift in the myeloid-erythroid ratio. The lungs show edema, adhesions and sometimes emboli.

Clinical Findings and Diagnosis

The disease appears most commonly in the third and fourth decade, although cases in children and elderly people have been recorded. There is no sex or racial predilection and no evidence of congenital origin. The patient usually comes to the physician because of the passage of a dark urine and/or other symptoms of chronic anemia including weakness, tiredness, pallor, jaundice, and vague muscular aches and pains. The most immediate danger is venous thrombosis[16, 17] as they not uncommonly occur cerebrally. Venous thrombosis can be seen anywhere in the body, however, and especially in the veins of the arms or legs.

The diagnosis of PNH is difficult and must be suspected in any patient with an obscure anemia. The anemic symptoms may be mild and hemoglobinemia infrequent or absent. In most patients the course is chronic. It may not be severe but often there are incapacitating exacerbations spaced by remissions ranging from days to years. The Ham Acid-Serum test,[18] if carried out with adequate controls, is considered diagnostic. This test is based upon the susceptibility of the PNH cells to lysis on slight acidification in vitro. Another characteristic finding is the rapidity with which lysis occurs if the patient's blood is allowed to stand at room temperature or at 37 C.[19] Crosby also demonstrated increased lysis if thrombin is added to acidified serum.[9] Some observers have also demonstrated a greatly increased sensitivity of PNH cells to hemolysis by high titer cold antibodies or, in the case of group A patients, to Anti-A antibodies. Hemosiderin has also been demonstrated in the urine of the PNH patients by using the Prussian Blue reaction.

Treatment

As the specific defect in the PNH erythrocyte is unknown, no specific remedy is available. One of the early facts discovered about the disease was that a lowered pH of the blood would cause an exacerbation of the disease. This led to the use of alkalies in the treatment of the condition, but the results were unsatisfactory because a severe hemoglobinuria resulted when alkalies were withdrawn.[17, 18] ACTH and cortisone have been tried without significant benefit.[7, 20, 22] Epinephrine (Adrenalin) is considered to be of little or no value,[21] though Crosby noted that it can cause a short remission but this is followed by severe hemoglobinuria.[7] Heparin is thought to increase hemolysis by impeding the heat labile inhibitor in the properdin system and dilute protamine also increases hemolysis by blocking the heat labile inhibitor. Bishydroxycoumarin (Dicumarol) is important in reducing thrombotic episodes which so often occur in the PNH patient.[22] It may also have some indirect action in that the thrombin labile inhibitor is spared when prothrombin, and thus thrombin, is decreased. Antibiotics are used supportively to reduce the danger of infections, but they have no effect on the primary disease. Splenectomy has been tried but without success and usually with a high mortality.[7] Some reports, however, indicate some benefit from splenectomy.[16, 22, 23]

Blood transfusions are the most beneficial of all treatments. Saline-washed red blood cells have been used to lessen febrile reactions when they become a serious complication in whole blood transfusions.[24, 25] Febrile episodes will usually also occur in time even with the use of saline-washed red blood cells. If the buffy coats are removed, the transfusion reactions can again be eliminated or at least considerably attenuated for a period. The primary aim in treatment, at least until more specific measures are available, should be to keep the patient alive and hope for a remission since this disease will often "burn itself out" in time.

Summary

1. A case of paroxysmal nocturnal hemoglobinuria is presented.

2. The known facts concerning the pathologic mechanism are reviewed.

3. The current therapy of the disorder is discussed.

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Psychiatric Residency Training Stipends Available to Physicians

To provide support at an adequate level for psychiatric residency training for physicians in practice who wish to become psychiatrists there are available training stipends up to a maximum of $12,000 a year. The level of payment will be determined by the training institutions who will also make the award to the individual physicians. The National Institute of Mental Health will make awards of grants for this purpose to training institutions and not to individuals. Physicians interested in support for this type of training should apply to training institutions which are approved for psychiatric residency training. Inquiries about the program should be sent to Dr. Seymour D. Vestermark, Chief, Training Branch, National Institute of Mental Health, National Institutes of Health, Bethesda 14, Maryland.

TRAUMA SYMPOSIUM*

A Series of Five Articles

Madison, Wisconsin

I. Overall Management of the Severely Injured Patient

By JOHN R. STEEPER, M. D.

Department of Surgery

Traumatology has become one of the largest fields of surgery. Although injured patients come under our care almost daily, our handling of these traumatic surgical problems is apt to be inferior to our performance in the other areas of surgical practice.

Several factors contribute to poor management of the injured patient: Injuries, especially those due to highway mishaps, are apt to be complex, and there is no "routine accident" case comparable to a "routine appendectomy" or "routine delivery." Furthermore, accidents seem prone to occur either in the dead of night or in the middle of busy office hours when thorough, deliberate action is difficult to attain. Finally, most accidents appear to generate an atmosphere of urgency so that it is easy to fall into the trap of hasty action which may compromise surgical principles.

It is well to have in mind a preconceived course of action to follow when approaching the severely injured patient, so that examination and treatment proceed in an orderly fashion. Such a course of action will eliminate most of the confusion and wasted effort so commonly seen in the accident room. Also, one should remember that there are very few emergency situations which will not permit deliberate and orderly management.

The following steps have been useful to us in treating the severely injured patient, and are given in the order of their priority:

1. *Establishment of airway:* Anoxia is potentially the most rapid cause of death. Many factors may cause obstruction of the airway in the injured patient: unconsciousness, blood and vomitus in the airway, fracture of the maxilla and/or mandible, and injury to the lungs or rib cage. The first efforts should be directed toward correcting these conditions. Positioning of head and tongue, aspiration of blood and vomitus, insertion of mechanical airway, and tracheotomy are frequently lifesaving procedures.

2. *Control of hemorrhage:* This is usually accomplished most effectively by direct pressure dressing until definitive surgery can be carried out. Tourniquets are rarely used.

3. *Treatment of shock:* Impending or well established shock demands immediate attention. Every hospital or doctor's office receiving accident victims should have one of the blood substitutes, dextran (Gentran), readily available for immediate use. These solutions are remarkably effective in temporarily restoring circulating blood volume while whole blood for transfusion is being obtained. Because of the danger of homologous serum jaundice, we do not use plasma. Adequate blood replacement is, of course, fundamental to good treatment.

4. *Examination:* Only after an adequate airway is assured, bleeding stopped, and shock treatment instituted is the patient thoroughly examined. Such an examination should be done under optimal conditions; *i.e.* good lighting, a warm room, and, most importantly, with the patient completely undressed. The examination should proceed systematically from the top of the head to the tips of the toes. It cannot be stressed too frequently that in the automobile accident victim, multiple widespread injuries are the rule rather than the exception. Anything less than complete examination will result in overlooked injuries.

5. *Recording observations:* At this point there is often an interval while a transfusion is being given; recovery from shock is

* Postgraduate meeting presented at the Jackson Clinic and Foundation, Madison, April 17, 1958.

awaited; or the operating room is being readied. During this brief period the alert physician will dictate, or otherwise record, the complete observations of his examination. These details, set down while fresh in the mind, are complete and accurate, and will prove invaluable as the basis for later insurance reports or testimony.

6. X-ray examination: This is purposely given a low priority since, with a few exceptions, x-ray examination is not an emergency matter. X-ray examination of broken bones is, of course, essential before definitive orthopedic treatment is instituted. Bone and joint surveys are wise for medicolegal reasons. However, only after the injured patient's condition has been well stabilized should he be moved to the x-ray department for such studies.

7. Definitive treatment: Upon completion of the previous steps, the physician can proceed safely to the suturing of lacerations, reduction of fractures, surgical exploration of the abdomen, or whatever form of treatment seems indicated, secure in the knowledge that nothing has been neglected and that each phase of management has been done in logical order.

II. Head Injuries

By GEORGE A. BERGLUND, M. D.

Consulting Neurosurgeon

In the treatment of head injuries priority must be given to control of vascular shock. This includes hemostasis. The scalp has a rich blood supply and thus, when lacerated, bleeding is brisk. In large lacerations hemostats should be applied directly to the galea rather than attempting to control individual bleeding points. Temporary through-and-through sutures may be placed and, if available, scalp spring clips afford excellent control. Hair must be shaved in the affected area, the wound profusely irrigated and debrided. The calvarium may be directly palpated by the sterile, gloved finger to determine break in the bony continuity. Simple lacerations may be closed with through-and-through interrupted sutures incorporating all layers of the scalp. Drains are usually not necessary but, if placed, should be brought out through a separate stab wound.

Evaluating for skull fracture is aided by x-ray. When should they be taken? This question has evoked controversy. A lateral portable scout film may be taken without moving the patient, and affords opportunity to evaluate for a large depressed fracture or a linear fracture crossing the middle meningeal artery groove. Linear fractures need no treatment per se. However, if these cross the meningeal artery groove or cross over the location of a large dural (venous) sinus, we must exercise more than ordinary vigilance for the development of an extradural hematoma. The so-called "windshield" or dented ping-pong ball fracture, although not infrequent in the infant, is rarely seen in the adult because of the increased bone thickness. When present, it can usually be sprung up rather easily by placing a small trephine opening adjacent to the depressed area and the bone elevated by upward pressure on the instrument inserted through the trephine opening. This should be done as a delayed procedure rather than through the contaminated wound. Comminuted fractures are nearly always compound and depressed. When depressed, dural rents and even cortical lacerations may be present. Comminuted depressed skull fractures are best handled at the time of primary repair; but if the depression is minor, not associated with neurologic deficit, and overlying a so-called silent area of the brain, elevation may be deferred until it is reasonably certain that infection will not develop. Fragments overlying and thus possibly invading the area of the motor cortex should be elevated early.

Intracranial hemorrhage either extra- or intracerebral must be considered in all head injuries however slight. The extradural hematoma usually results from laceration of a middle meningeal artery branch or from tear of one of the larger dural sinuses. Bleeding is therefore brisk, and the development of signs and symptoms of increasing intracranial pressure develop more swiftly than in the case of the subdural hematoma which usually result from a stretching or shearing type tear of a smaller type vein traversing the subdural space from the cortex to the dura. You will recall the typical textbook description of an extradural hematoma development as an initial period of unconscious-

ness caused by the concussion, followed by a lucid interval and then, within a matter of hours, increasing drowsiness, stupor and coma, as the intracranial pressure increases. This is a true neuro-surgical emergency, and it is frequently necessary to expose a large area by turning a bone flap in order to adequately evacuate and control the bleeding hematoma.

We may consider subdural hematoma as being either acute or chronic. In the acute form there is usually an associated laceration of the cortex, signs of increasing intracranial pressure and/or of increasing neurologic deficit which may develop in a matter of hours or days. Because of the associated cerebral damage, the acute subdural hematomas are indeed more formidable than the chronic type; and the mortality as well as morbidity is relatively high. The chronic subdural hematoma manifests itself within a matter of weeks or even months after the injury. Headache is the most common signal, secondly is so-called "dizziness", lethargy to frank drowsiness with or without evidence of neurologic deficit. As a result of the initial injury, a blood clot forms in the subdural space, a connective tissue envelope forms from the fibroblasts of the meninx. This envelope acts as a semipermeable membrane. As the red blood cells break down into an increasing number of complex protein molecules, the osmotic pressure increases. In an attempt to decrease this osmotic pressure, fluid is drawn into the enveloped hematoma; thus it increases in size. These are readily treated by drainage and in the infant by removal of the capsule. The latter is important in the infant so that the capsule lying on the cortex does not impede growth of the otherwise normally developing brain. Subarachnoid bleeding is usually not a problem in itself but indicates either cerebral laceration, tear of a vessel within the subarachnoid space, or subdural bleeding with an associated arachnoidal tear.

Cerebral trauma: Concussion may be defined as a transitory disturbance of brain function not associated with structural alteration. It is a physiologic disturbance, and reversible. When there is structural damage, we think in terms of cerebral contusion. This is associated with petechial or even more profuse hemorrhage. Cerebral laceration is associated with hemorrhage. Intracerebral hematoma from this cause is not rare and it, too, may be a surgical emergency. The hematoma is evacuated and hemostasis secured. In this type of hematoma one may observe a striking degree of neurologic deficit (e.g. paralysis) with relatively little deterioration in the state of responsiveness. This is in contrast to the extradural hematoma.

Head injuries are sometimes classed as "open" or "closed." The "open" ones are those treated surgically and the "closed" ones those treated medically. During the first few days and especially in the first few hours it is impossible to determine that a specific head injury will be a "closed" one. We must always be on the alert for the development of increased intracranial pressure due to intracranial hematoma. Typical changes of blood pressure, pulse, and respiratory rates resulting from increasing intracranial pressure are well known. It might be well, however, to emphasize the importance of using the patient's state of responsiveness as an additional criterion. You will observe in figure 1 that changes in the state of responsiveness associated with progressively increasing pressure may be likened to the changes occurring in anesthesia. On one end of the scale we have lucidity; and, as the intracranial pressure increases, there is restlessness or confusion, drowsiness, lethargy, stupor, coma, and at the far end, death.

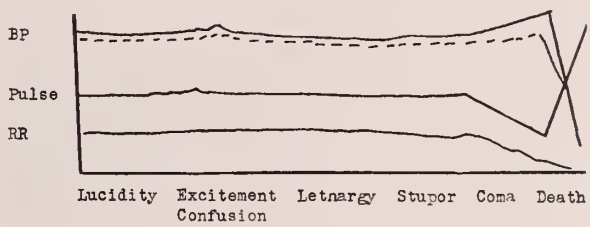

Figure 1

Blood pressure changes usually do not occur until we are well in the state of coma, and then we get a rise in blood pressure, especially systolic. Associated with this may be a bradycardia. Thus the finding of a slow, forceful (widened pulse pressure) pulse is a poor rather than a good omen. As intracranial pressure progresses we reach a state of "cerebral decompensation" or of medullary compression. The blood pressure falls precipitously, pulse rate becomes rapid and thready. We have peripheral vascular collapse. Likewise, respiratory rate changes do not occur until we are well in the state of coma. It is the slow rate, the periodic apnea of Cheyne–Stokes type respiration, or the

deep-sighing, irregular, slow, respiratory efforts which develop until final apnea. In the typical cerebral death, apnea precedes cardiac standstill. By watching the changes in the state of responsiveness, we provide ourselves with a longer period of forewarning. We cannot rely solely upon blood pressure, pulse, and respiratory changes because by the time they are evidenced, the optimum time for surgical intervention may have passed.

The following orders on the hospital chart are recommended for patients with head injury:

1. Blood pressure, P, R q 1 hr. x 12, then q 2 hrs. x 12
2. Awaken q 2 hrs., night and day
3. Notify stat. if
   a. Progressive rise of blood pressure, or if
   b. Pulse rate falls below 60/min., or if
   c. Respiratory rate falls below 12/min., or if
   d. Deterioration in state of responsiveness.
4. Elevation of head of bed for blood pressure over 100 mm. Hg systolic (This is done to facilitate venous drainage and thus lessen filtration pressure and resultant edema.)

In the treatment of any head injury the most important consideration after securing hemostasis is attention to the maintenance of an adequate and free airway. There is frequently associated facial injury with bleeding into the oropharynx, and for these as well as for those cases of increased mucous secretion, uncontrollable by suction, that tracheotomy is indicated. Hypoxia and accumulation of carbon dioxide increases cerebral vessel dilation. This, of course, augments cerebral edema, and cerebral edema is a major concern. Thus the importance of a free airway cannot be over-emphasized.

What is the place of lumbar puncture in the case of head injury? There is some danger in promoting a tonsillar pressure cone. This is especially true if a posterior fossa hematoma is suspected. Also, lumbar puncture should not be done in those cases of cerebrospinal otorrhea or cerebrospinal rhinorrhea lest bacteria be "sucked" in to the meninges.

Hypertonic solutions such as 50% glucose or sucrose, urea, and concentrated plasma have a place. Urea is preferred.

Cerebrospinal otorrhea almost always subsides spontaneously within a matter of days. It is important to protect prophylactically with antibiotics. Cerebrospinal rhinorrhea, on the other hand, may be extremely troublesome and even necessitating craniotomy with repair of the dural rent.

Bleeding from the external auditory canal or blood accumulating posterior to the tympanic membrane is usually found with a middle fossa basal skull fracture. There is frequently ecchymosis over the mastoid process (Battle's sign). These usually clear spontaneously, but for those with resultant hearing deficit, otologic evaluation should be obtained.

III. Vascular Injuries

By LUTHER E. HOLMGREN, M. D.

Department of Surgery

Interest in vascular surgery was greatly stimulated by the large number of wounds to blood vessels suffered in the second World War. A great deal of work was done in the post World War II period in reconstruction and repair of some of those injuries in which the patient had survived the initial trauma and was suffering from one or another sequela of vascular injury. During the Korean War much of the information obtained by this previous experience was applied to acute injuries, and much more experience was gained. Since then, with the advent of homografts and synthetic grafts, tremendous strides have been made and are continuing to be made in this field. A visit to any of the large medical centers at the present time will show a tremendous increase in the number of vascular surgical cases. Vascular services have now taken their place with the other major branches of surgery. With increased knowledge and experience, it is now possible to have a systematic plan of procedure for vascular injuries. By prompt and adequate attention, it is possible to save many limbs which ordinarily would have been lost due to ischemia.

A simple classification of arterial injuries makes it possible to illustrate the common types of injuries and some of the differences in treatment. The classification I am showing here is not original but is commonly used by most surgeons. Any of these types may occur in an automobile accident.

The first type, the simple incision or laceration, is the type of injury caused by damage to a vessel by a sharp cutting instrument. In this type of injury the vessel may be completely transected with retraction of the ends of the artery, or the vessel may be only partially cut through leaving a gaping opening in the wall of the artery. The vessel which is completely transected is apt to bleed less and for a shorter period than the vessel which is only partially severed. The reason is that the severed vessel retracts into the muscle and soon contracts, permitting formation of a thrombus, which will control the bleeding entirely or partially. When the vessel is not completely transected, the ends of the artery do not pull apart and blood loss is apt to be more profuse and prolonged.

The second group is the perforating type of injury in which the artery is pierced, either by a small, sharp instrument, such as an ice pick or small knife, or by a high velocity missile of small size. Blood loss in this type of injury is much less, and there may be little external bleeding. However, this is the type of injury which is particularly prone to produce a so-called "false aneurysm" or pulsating hematoma. This condition results when there is bleeding from a small perforation in an artery and there is sufficient tissue resistance in the area to build up a hematoma, which eventually will have the same pressure as the pressure in the artery. When this stage is reached, there is no further bleeding, but there is an escape of blood into the hematoma with systole and backflow from the hematoma to the vessel on diastole. The hematoma may be rather large and is characterized, as is a true aneurysm, by the pulsating mass.

In the days before our present knowledge and facilities for vascular repair, this type of lesion was left alone in order that collateral circulation could be established. Several months were customarily allowed to elapse before any definitive surgery. The vessel then was generally ligated above and below the hematoma and the injured area resected. Though this often saved the limb, the collateral circulation was never sufficiently adequate to give a normally functioning extremity. Today such delay with the eventual excision of the artery is no longer practiced. The false aneurysm is repaired as soon as the diagnosis is made, using one of the methods which I will describe later.

Perforating injuries to vessels commonly produce arteriovenous fistulas, inasmuch as this type of injury will frequently injure the vein at the same time the artery is injured and permit a flow of blood from one vessel to the other. Again, it was the former practice to do nothing about these fistulas until sufficient time had elapsed for collateral circulation to become established. After several months an excision of the fistula with ligation of all four limbs of the artery and vein was done, and the fistula with the adjacent vessels was excised. As with the "false aneurysm" the modern method is to carry out definitive treatment immediately.

The third type of arterial injury is the contusion caused by a broad, crushing or grinding force or by a relatively slow missile which damages the artery without actually severing it. Still another type of injury which may produce contusion of an artery, and one which is being seen more and more commonly, is that caused by a high velocity missile coming close to the artery and not actually hitting it. This type of injury may result in considerable damage to tissues at a distance from the actual site of the entrance or exit of the missile. Fractures commonly cause this type of injury to a vessel if the fractured bone impinges on the vessel without severing or puncturing it. In this type of injury there is usually no bleeding from the vessel itself, but bleeding may occur into the wall of the vessel producing an intramural hematoma which may eventually occlude a small vessel. Or, injury to the wall may cause formation of a thrombus. The importance of this type of injury is that it may not become evident until hours or even days after the original injury. Initial examination may show good pulsation of all peripheral vessels, resulting in a false sense of security. Several hours later, with formation of the intramural hematoma or a thrombus, the vessel may become completely occluded; and valuable time may be lost before the diagnosis of occlusion is made. Therefore, it is particularly important that extremities suffering crushing injuries be watched carefully for evidence of occlusion of any of the major vessels in the area of the injury.

As a general rule, it is not difficult to determine that a major vessel has been injured. If an open wound is present, the type of bleeding indicates major vessel damage. However, in cases in which there are marked contusions of an extremity without any actual open wound, it is sometimes difficult to be

sure whether or not a vessel has been severely damaged. In this type of injury there is almost always a marked spasm of all of the arteries of the extremity, and occasionally it is impossible to determine without further specific examinations whether a large vessel is occluded or severed, or whether the failure to find peripheral pulsations is due to spasm. Spasm usually can be alleviated by interruption of the sympathetic nervous system reflex by the injection of procaine into the paravertebral sympathetic ganglia. Occasionally, in spite of all efforts, it may be necessary to resort to arteriography to establish the correct diagnosis.

The treatment of arterial injury can be divided naturally into three phases. The first problem, of course, is control of hemorrhage. In many cases of arterial bleeding, pressure alone is sufficient. If pressure does not control the hemorrhage adequately, a tourniquet must be applied above the site of injury. Arterial injuries in areas that cannot be controlled by pressure or by a tourniquet, such as injuries in the abdomen, chest, axilla, or high in the groin, will usually bleed so profusely that the patient will not survive without immediate surgical intervention to control the hemorrhage, combined with rapid transfusion to prevent or correct shock.

After the bleeding has been controlled, the second phase of treatment consists of combating the shock brought on by trauma and the loss of a large amount of blood. Whole blood is, of course, the first choice in the restoration of blood volume. However, in an emergency where blood is not immediately available, plasma or one of the volume expanders such as dextran can be used. Rapid infusion of saline may be used if no other solution is available but is not a very satisfactory method of expanding the blood volume.

The third phase of the treatment involves repair to the damaged vessel in an effort to restore normal circulation to the extremity. It must be emphasized that if adequate facilities for this type of repair are not available, the patient should be transferred with as little loss of time as possible to a hospital where such care can be given. Time is of the utmost importance if the ischemic part is to be saved. The first step in the definitive treatment of a damaged vessel is to gain control of the vessel, first in a site proximal to the damaged area where the vessel can be exposed through relatively normal tissue. After this has been accomplished, the same procedure is carried out distal to the wound where the vessel is again controlled without getting into the damaged area itself. Once the vessel is under control proximally and distally, then an attack is made on the damaged area itself.

The repair of the vessel depends on the nature of the injury. The sharp incision in an artery is simply sutured with an over-and-over suture of fine silk on an atraumatic needle. A transected vessel in which there is no loss of substance may be repaired by an end-to-end anastomosis. Where there has been considerable damage to the vessel with loss of substance, it is necessary to resect the damaged portion of the vessel and to restore its continuity by one method or another. Even with considerable loss of substance in a vessel, particularly in a young person, it is surprising how much elasticity there is in the vessel, permitting even a large gap to be bridged by freeing the vessel, stretching it, and bringing it together by primary anastomosis. If this cannot be accomplished, it is necessary to restore the continuity of the vessel by a graft. The type of graft used will depend, of course, on what is available.

Venous grafts to repair arteries are relatively satisfactory and the vein which lends itself well to use as a graft is the saphenous vein. This vein can be spared without damage, and it is a rather muscular vein which adapts itself rather well to use as a graft. We have used veins to repair arteries when nothing else was available, and they have been eminently satisfactory. It is important to orient the vein properly. That is, the vein must be put in backwards, so to speak, inasmuch as the vein has valves which would interfere with the normal flow of blood if the vein were put in with its normal polarity. At the present time most medical centers have stored homografts available; these are probably the best grafts as far as our present knowledge is concerned.

Recently, artificial prostheses made of nylon or other synthetic materials have been placed on the market. They are convenient and can be obtained in any size, shape, and length. They have been used for a sufficiently long period of time to prove that they make satisfactory vessel replacements. I wish to emphasize, however, that the long-term follow-ups of the use of stored homografts and on the use of artificial prostheses have not been as encouraging as were the earlier reports. It has been shown that many of

these grafts eventually begin to deteriorate and changes occur in them which produce dilatation, thrombosis, and eventual obliteration of the graft with resultant ischemia of the limb. It must be remembered that many of these grafts were used to replace arteries which were diseased; and any periods of comfortable existence which they produced were of great benefit to the patients, many of whom were individuals who would eventually have lost their limbs or their lives because of occlusive arterial disease. However, in traumatic cases one is frequently treating young people and whatever is used to restore the continuity of the vessel may have to last for 10, 20, 30, 40, or 50 years. There is a question in my mind whether either arterial homografts or synthetic prostheses will last this long.

IV. Treatment of Acute Thoracic Injuries of Any Injured Person

By OSCAR F. FOSEID, M. D.

Department of Thoracic Surgery

When one first sees an accident victim in the emergency or operating room, there is the question: "What to do first; where to begin?" Obviously, severe bleeding from a severed vessel in the arms, legs, or neck, or a sucking wound of the chest wall gets prior treatment.

The most important principle is to ensure adequate ventilation. Asphyxia must be relieved and maximum oxygenation established, because anoxia can cause or aggravate circulatory failure. Therefore, establishing and maintaining a patent tracheobronchial airway is vital.

Many automobile injuries involve the head and face with contusions of the nose and mouth and bleeding into the nasopharynx. If the patient is unconscious, he is unable to clear the tracheobronchial tree by coughing and must be helped mechanically:

1. Position:
   A. Head down Trendelenberg position is best.
   B. Airway will help hold base of tongue up. Sometimes it is necessary to hold the tongue up with a towel clip.
2. Aspiration:
   Can use an ordinary suction tip to clean out the nasopharynx. To cleanse the trachea pass a semirigid catheter of no. 16 size by way of either mouth or nose. Suction should not be left on too long (30 seconds), as too much oxygen will be removed in a patient already in respiratory embarrassment.
3. Tracheotomy:
   A. Permits easy and frequent aspiration of tracheobronchial tree.
   B. Need not worry about tongue falling back and obstructing the larynx.
   C. Respirations can be assisted by connecting an oxygen bag to the tracheotomy tube and using forced hand breathing.
   D. Also shortens the distance the patient has to suck in the air and reduces respiratory fatigue.

Open chest wounds are commonly called "sucking wounds" because of the harsh sucking sound heard on inspiration. These have only an entry and are the result of an object penetrating the chest wall and producing a sinus tract or opening. On inspiration, more air enters the pleural cavity, causing the lung on that side to collapse, than enters through the glottis into the good lung and the mediastinum is displaced to the good side. On expiration, the reverse occurs, and the mediastinum swings back causing "mediastinal flutter." As a result, there is a useless exchange of poorly oxygenated air between the two lungs and impairment of the circulatory dynamics of the heart and great vessels.

The location of the apical impulse is a clue to the degree of mediastinal shift. If it is at or near the anterior axillary line, the shift has been considerable. Intrathoracic air or bleeding of this degree requires some type of operative intervention. The initial treatment is the application of an occlusive pressure dressing of sterile vaseline gauze to seal the opening. This converts the open to a closed pneumothorax. Then place a catheter in the second anterior interspace in the midclavicular line to avoid injuring the internal mammary vessels. This can be connected to suction or the end of the tubing placed in an underwater seal bottle.

Pneumothorax:

Pneumothorax occurring as the result of an accident may have as its etiology: (1) the rupture of an emphysematous bleb, (2) the tearing of a pleural adhesion from the lung surface, (3) a sucking wound of the chest

wall, (4) rupture of a portion of the lung surface from the force of the contusion, or (5) puncture of the lung surface with a foreign object. Any of these forces can cause an air leak with a valve-like mechanism. Air enters the pleural cavity but cannot leave, and the intrapleural pressure gradually rises and compresses the lung and pushes the mediastinum to the opposite side, compressing that lung also.

A single aspiration of air from the pleural space may be curative in some cases if the leak is small and seals over. Free air tends to occupy the upper portion of the pleural cavity, so the second intercostal space in the midclavicular line is the best site for the needle puncture. The patient should lie on his back with head and chest elevated.

If respiratory distress recurs and x-ray indicates the reformation of the pneumothorax, then continuous aspiration is necessary.

The average case re-expands in three to four days. The tube should be clamped off for 24 hours before removal to be certain there will be no recurrence of the leak.

If the leak fails to seal off, and this will be indicated by failure of the lung to expand, or if there is constant recurrent leakage of air, it then is necessary to do a thoracotomy and repair the lung.

Crushing chest injuries with paradoxical respiration:

Severe crush injuries of the chest with multiple rib fractures are increasing because of the high speed at which many accidents occur. This type of injury seems to happen most frequently to the driver from the impact against the steering wheel. A large number of ribs are broken anteriorly and posteriorly and is referred to as a "stove-in chest." Shock, hemothorax, "wet lung" syndrome, and pneumothorax are often present.

The portion of the chest wall between the broken rib ends is unstable and moves in the opposite direction from normal with each respiration and is called paradoxical motion. This causes intense pain with each respiration and cough and interferes with the exchange of air and a suppression of the cough necessary to bring up the tracheobronchial secretions. Fluid collects, and the patient is unable to remove it by coughing, and a "wet lung" results. Consequently, the oxygenation of the blood is impaired. The crushed chest is an emergency that requires prompt treatment. The loose part of the chest wall must be fixed. This can be done in several ways.

Select a rib in the center of the loose portion of the chest wall, and under local anesthesia make an incision down to the rib and fix the same with a towel clip or wire. In a thin person with prominent and easily visible ribs, the towel clip could be passed through the skin and about the rib without the incision or to adhesive attached to the skin. The towel clip is then fixed to a cord which passes through a suspended pulley, and enough weight is attached to prevent paradoxical motion. This usually requires about five pounds on the average.

Often placing the patient on the injured side will help to splint the chest wall.

Hemothorax usually results from injury to intercostal vessels, but the internal mammary and pulmonary vessels and the lung structure itself are sometimes involved.

The patient is in shock and this usually means blood loss. At the moment you may not know the site of the bleeding. Transfusions are imperative, but care must be taken not to overtransfuse.

If the blood is not removed, it may take weeks to absorb, if at all. As an end result, there will be pleural thickening, fibrous covering of the lung, and fibrothorax with limitation of pulmonary function.

Good routine to follow in treating hemothorax is:

1. Do thoracentesis first. Repeat chest x-ray in about 12 hours to see how much bleeding has recurred.
2. If bleeding persists, slip in a catheter for constant suction and to keep lung expanded against chest wall.
3. If bleeding still persists, a thoracotomy is necessary to find the bleeding points.

Injuries to the heart and pericardium:

If the heart and pericardium have been bruised, a hemopericardium may occur. Clinically, the heart sounds are muffled, there is a small pulse pressure, hypotension, and engorged neck veins. If there is a persistent tachycardia and irregular pulse, myocardial contusion should be suspected. An electrocardiogram is important because the patient should be kept at complete bed rest until tracings return to normal.

The situation can be relieved by aspiration through the left fourth or fifth interspace

or passed upward between the xiphoid and costal cartilage margin. These aspirations can be repeated as required.

General care of chest injuries:

1. These patients like the semi-sitting position best, probably because partial splinting of the chest wall takes place and motion of fractured rib ends and bruised or torn intercostal muscles does not take place.
2. Blood lost must be replaced, but be cautious not to overload the patient or pulmonary edema will occur.
3. Use of oxygen is indicated and in any circulatory failure is imperative.
4. Analgesic drugs should be used only in small doses and then only when the patient has recovered from the shock condition.
5. Simple rib fractures are common, and the pain caused may be controlled by simple adhesive strapping. If not, intercostal nerve block injections with 1% procaine can be given. It is necessary to inject the two spaces above and below the painful area for maximum relief. Use about 5 cc. at each injection site, and these can be repeated as necessary.
6. Physiotherapy or dry heat treatments to the painful area gives marked relief of pain.

V. Orthopedic Aspects of the Automobile Accident Patients

By HOWARD W. MAHAFFEY, M. D.

Department of Orthopedic Surgery

Injuries which result when the body is abruptly decelerated are multiple and varied. No definitive treatment can be properly instituted until the patient has been completely evaluated. Often other injuries must be treated before definitive treatment of fractures is initiated. After establishment of an adequate airway and the treatment of shock, the patient can be thoroughly examined and the injuries enumerated. Deformity, hematomas, and contusions may lead to discovery of underlying fractures of bones. The function of tendons and nerves must be determined.

Early x-ray examination of the severely injured person should be limited. Often these are taken with portable equipment and are limited to views necessary to determine the early care of the patient. After function of the respiratory and cardiovascular systems is stabilized, a more detailed x-ray examination can be made. Before operative repair of a fracture of a long bone, x-ray examination must show the shaft from the distal to the proximal end so that other fractures are not missed.

When other injuries require treatment first, the musculoskeletal injuries should be splinted with pressure dressings, temporary plaster splints, or skeletal traction until definitive treatment can be performed. The use of a yacca board splint should be discouraged except for temporary splinting to transport the patient. Recognition and treatment of injuries to the brain are of utmost importance. Injuries to the chest that may result in respiratory embarrassment also take priority over the musculoskeletal injuries. Suspected intra-abdominal injuries must be evaluated and the opinions of the general surgical consultant followed before a patient is subjected to major operative repair of a fracture. A rupture of a solid or hollow viscus must be recognized early and receive immediate care. When a fracture of the pelvis is present, a urine specimen must be obtained; and if gross blood is present, a cystogram should be made before the patient is moved to determine whether the urinary bladder has been injured. When a large artery of an extremity is ruptured by a fracture of a long bone, fixation of the fracture is essential to give more stability to the leg or arm at the time of the artery repair.

When compound fractures occur, they must be treated early. Antibiotic therapy is started and tetanus antitoxin or toxoid is administered. The value of gas bacillus antitoxin is questionable, but if there is considerable contusion of muscle, its use may be indicated. If other injuries are mild, fractures can be treated as soon as shock is controlled.

Under a general anesthetic and with the use of a pneumatic tourniquet when practical, the wound is covered with sterile gauze. The surrounding skin is thoroughly scrubbed with a surgical detergent. The wound is then thoroughly irrigated to remove foreign material. Free fragments of bone should not be discarded but should be placed in sterile sa-

line. If dirt has been ground into the tissue, the wound can be scrubbed with a sterile brush and a surgical detergent. After thorough mechanical preparation including irrigation, the fracture can be reduced and the proper appliance used for internal fixation where indicated. Any free bone fragments should be cleaned and replaced at the fracture sight as a free graft.

Detailed attention must be given to the soft tissue injury. Muscle must be removed, frayed tendon ends debrided and repaired, and devitalized skin removed. The open fracture is converted to a closed fracture by closure of the skin using a relaxing incision or by sliding a flap of skin across the wound. Split thickness grafts can be used to cover any defect left by the secondary incisions.

If other injuries preclude early definitive treatment of compound fractures, the wound should be irrigated well and packed with nitrofurazone gauze. The fracture can be splinted with a well padded plaster cast, pressure dressing, or skeletal traction. A fine Kirschner wire can be inserted using local anesthesia without harm to the patient who has other serious injuries.

Small wounds without gross contamination may be sutured primarily even though further treatment may be temporarily inadvisable. When antibiotics are used, a period of 12 to 18 hours may safely elapse before definitive treatment of a compound fracture is undertaken.

Primary amputation of a mangled extremity is seldom indicated. Debridement and repair should be done as early as possible with the hope of maintaining a useful extremity. Amputation may be done at a later date if indicated, and the patient is always grateful even for the futile attempt.

I should like to point out again that too many x-rays may be unwise initially in a seriously injured patient, but too few x-rays may leave fractures undiagnosed. A patient with a fracture of both bones of the forearm may also have a fracture of the carponavicular or a fracture of a metacarpal shaft. A fracture of the elbow may mask the symptoms of an impacted fracture of the neck of the humerus. The force which causes a fracture of a patella may produce a fracture of the acetabulum with or without dislocation of the hip. A fracture of the shaft of the femur may be associated with a fracture of the neck of the femur, or the same force which fractured the shaft of the femur may also disrupt the ligaments of the knee. A spiral fracture of the distal one-third of the tibia is almost always associated with the fracture of the proximal end of the fibula. The pain from a fracture of the pelvis may be so severe that the patient is not aware of the pain from a compression fracture of a vertebra, and palpation of the spinous processes cannot be done because of severe pain which is produced on turning the patient.

Injuries to the peripheral nerves are common with some fractures. These must be suspected with spiral fractures of the mid shaft of the humerus, dislocation of the hip, and fractures of the lateral tibial plateau and neck of the fibula. If the patient cannot dorsiflex the wrist, there is damage to the radial nerve. Inability to dorsiflex the first toe indicates an injury along the course of the common peroneal nerve. The ulnar nerve is vulnerable at its bony groove in the humeral condyle, and the median nerve is subject to injury just beneath the palmaris longus tendon at the wrist.

Fractures of the vertebrae with neurologic deficit demand immediate steps to determine the amount of damage to the spinal cord. The level of skin anesthesia must be determined and the muscle weakness evaluated. If the injury involves the cervical spine, immediate traction must be applied with a head halter before the patient is moved for x-ray examination. The x-ray examination should include a lateral view taken with a portable machine to determine the amount of displacement. In fractures of the cervical spine, a spinal tap should be done early to determine the presence of subarachnoid block. If such a block is present, early decompression is necessary. Traction by means of a head halter cannot be applied for a long period of time, but skeletal traction, accomplished by placing tongs in the skull, can be used and sufficient weight can then be applied to reduce dislocation. Fracture-dislocations of the lower dorsal and lumbar spine do not demand immediate decompression as do injuries of the cervical spine. The patient should be placed in gradual hyperextension. If sensation does not gradually return and the dynamics of the cerebrospinal fluid show persisting block, adequate decompression should be carried out.

In summary, I would like to state that the concept of team care of the severely injured patient is the ideal one. After control of shock and asphyxia, evaluation of the patient

as a whole can be done to determine the extent of his injuries. Compound fractures of the extremities represent a true surgical emergency. However, at times the treatment of other injuries takes precedence. When other injuries must be treated first, the compound wound should be thoroughly cleaned, dressed, and splinted. Definitive care of the fractures which have been incurred should not be carried out until the patient's general condition is satisfactory.

ASSOCIATED FRACTURES

Forearm	Carponavicular Metacarpal Supracondylar
Humeral condyle	Surgical neck of humerus
Patella	Acetabulum
Shaft of femur	Neck of femur
Pelvis	Lumbar vertebra

PERIPHERAL NERVE INJURIES ASSOCIATED WITH FRACTURES

Nerve	Fracture	Symptoms
Radial	Humerus	Loss dorsiflexion of wrist.
Median	Distal radius	Loss sensation middle finger. Loss of opponens function of thumb.
Ulnar	Humeral condyle	Loss sensation little finger and adduction thumb.
Sciatic	Fracture, neck fibula	Loss of dorsiflexion of foot.
Common peroneal	Dislocation hip	
Tibial	Dislocation hip	Loss of plantar flexion of foot.

The Diagnosis of Meningitis

Meningitis is not uncommon in the newborn. Signs of meningeal irritation are often lacking in this age group, however, and this lack of the expected symptoms often leads to a late diagnosis and a marked increase in the number of deaths and sequelae.

Meningitis must be considered when a newborn displays any of the following symptoms:

- Jaundice
- Lethargy
- Refusal of food
- Pallor
- Hypotonia
- Cyanosis
- Vomiting
- Fever
- Convulsions
- Full Fontanel
- Shrill Cry
- History of maternal infection

In older children, meningitis must be ruled out whenever there is unconsciousness, irrationality, convulsions, stiff neck, Kernig's or Brudzinski's signs. Other things that suggest the possibility of meningitis are:

- Severe headache
- Vomiting
- Flare-up after U.R.I. or otitis
- Fresh strabismus
- Poor contact
- Petechiae
- Contact with tuberculosis
- Urinary retention
- Extreme drowsiness
- Lack of sufficient findings to explain clinical picture

If the diagnosis seems to be a definite possibility, a spinal tap should be done at once since antibiotics given in the usual manner serve only to mask the illness for a few days, make specific bacterial investigations less fruitful, and increase the morbidity and mortality.

Summary of talk presented by Reuben J. Snartemo, M.D., Milwaukee, at postgraduate course on "Pediatric Diagnosis and Treatment", February 5–26, 1959, Marquette University School of Medicine, Milwaukee.

ARTHRITIC PATIENTS WANTED

The University of Wisconsin Medical School is investigating some of the metabolic aspects of rheumatoid arthritis. Dr. John Z. Bowers, Dean, asks for the cooperation of Wisconsin physicians. Doctor Bowers says, "we are anxious to study patients who have active uncomplicated disease and who have not received steroid hormones for two months. About one week of hospitalization would be necessary for the studies or they could be carried out without hospitalization." Doctor Bowers would be happy to discuss the matter with any physicians who have such patients.

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Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

Biopsy Techniques in the Diagnosis of Intrathoracic Disease*

By BEN R. LAWTON, M. D.

Marshfield, Wisconsin

THE ADVENT OF survey chest x-rays, routine hospital admission x-rays, and the more frequent use of diagnostic chest x-rays has resulted in the production of a vast number of abnormal x-rays that defy diagnosis by conventional means. Focus on the problem has been further sharpened by the development in recent years of specific therapy for tuberculosis and several of the fungus infections. Corticosteroid therapy for certain of the noninfectious diseases has further complicated the picture.

In years past, the clinician faced with such a case had four choices, all bad:

1. If the patient were asymptomatic, the clinician could ignore the x-ray and hope for the best.
2. Or, if he were more conscientious, he could indulge in the popular sport of "serial x-rays" at six-week or three-month intervals. This choice is predicated on the theory that such x-rays have a definite period of gestation at end of which time the lesion will hatch —and sometimes it does.
3. Thirdly, if the patient were symptomatic, he could be treated empirically on the basis of the educated guess of the radiologist.
4. As a fourth choice, and one frequently taken, the patient could be subjected to a period of several weeks expensive hospitalization during which time innumerable negative tests are carried out, one by one. This ordeal frequently ends with the patient's serum going to Kansas City and the patient going to the chiropractor.

In the search for a more satisfactory solution to this problem, several useful but little used biopsy techniques have evolved. It is my purpose here to review our experience with these methods.

* Presented at meeting of Wisconsin Surgical Society, May 8, 1958, Milwaukee.

Methods

The procedures to be reviewed are: Scalene node biopsy, pulmonary biopsy, and pleural biopsy. Before discussing our results, I would like to briefly define and clarify the procedures.

Scalene node biopsy is done essentially as originally described by Daniels[1] with minor modifications. The procedure consists of the use of infiltration anesthesia for the removal of the scalene fat pad and far more importantly, the lymph nodes medial and anterior to the anterior scalene muscle. The angle between the subclavian vein and internal jugular vein is thoroughly exposed, frequently visualizing the thoracic duct or right lymphatic duct. It should be emphasized that the procedure is not considered a scalene node biopsy if supraclavicular nodes are palpable. It should further be emphasized that the procedure is not a simple excision of the scalene fat pad.

Pulmonary biopsy is a selective wedge excision of lung tissue under general anesthesia.[2] The procedure does not entail the danger, discomfort, or disability of standard thoracotomy. Hospitalization need not exceed two or three days.

Pleural biopsy, in our hands, also is done under general anesthesia with limited exposure for selective biopsy. We have had no experience with needle biopsy which has been reported with good results in some hands. The procedure is much more attractive to fearless internists than to surgeons.

Results

This report concerns 60 consecutive cases with only two criteria for selection. All had abnormal chest x-rays and in all cases, conventional diagnostic measures were not conclusive.

Of these 60 cases, 54 had scalene node biopsy, 13 had pulmonary biopsy, and 8 had pleural biopsy, for a total of 75 biopsy procedures.

Table 1—Incidence of Positive Biopsies

Scalene Nodes	
Pathologic	15 or 28%
Diagnostic	12 or 22%
Pulmonary Biopsy	
Diagnostic	13 or 100%
Pleural Biopsy	
Diagnostic	8 or 100%
Total Diagnoses Established	33 or 55%

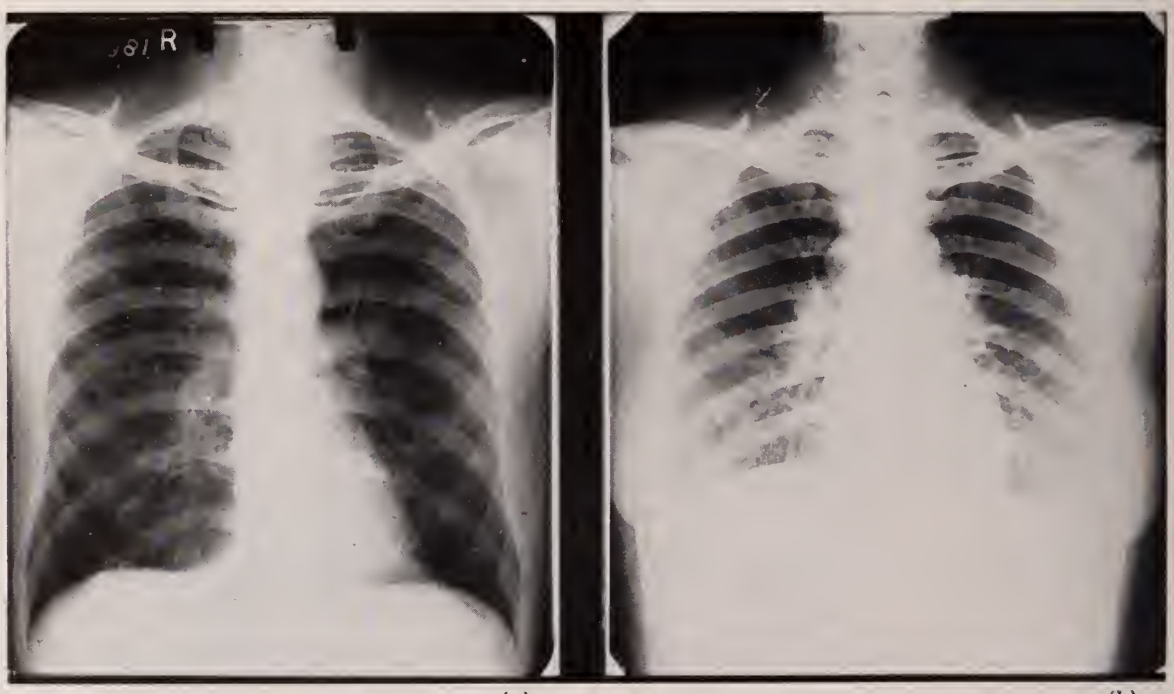
Table 2—Diagnoses Established By:

	No. of cases
Scalene Node Biopsy	
Sarcoidosis	5
Carcinoma	8
Histoplasmosis	1
Silicotuberculosis	1
Granuloma, nonspecific	3
Pulmonary Biopsy	
Farmers Lung	7
Sarcoidosis	1
Histoplasmosis	1
Eosinophilic granuloma	1
Tuberculosis	1
Bronchiolectasis	1
Fibrosis, nonspecific	1
Pleural Biopsy	
Tuberculosis	3
Carcinoma	3
Fibrinous pleuriti , nonspecific	2

The incidence of positive diagnosis is listed in table 1. It will be noted that a diagnosis was established by biopsy in 33 cases, or 55% of the series. Of the remaining 27 cases, a diagnosis was later established by thoracotomy in 13, and autopsy in 1. In 13 cases, microscopic diagnosis was not established.

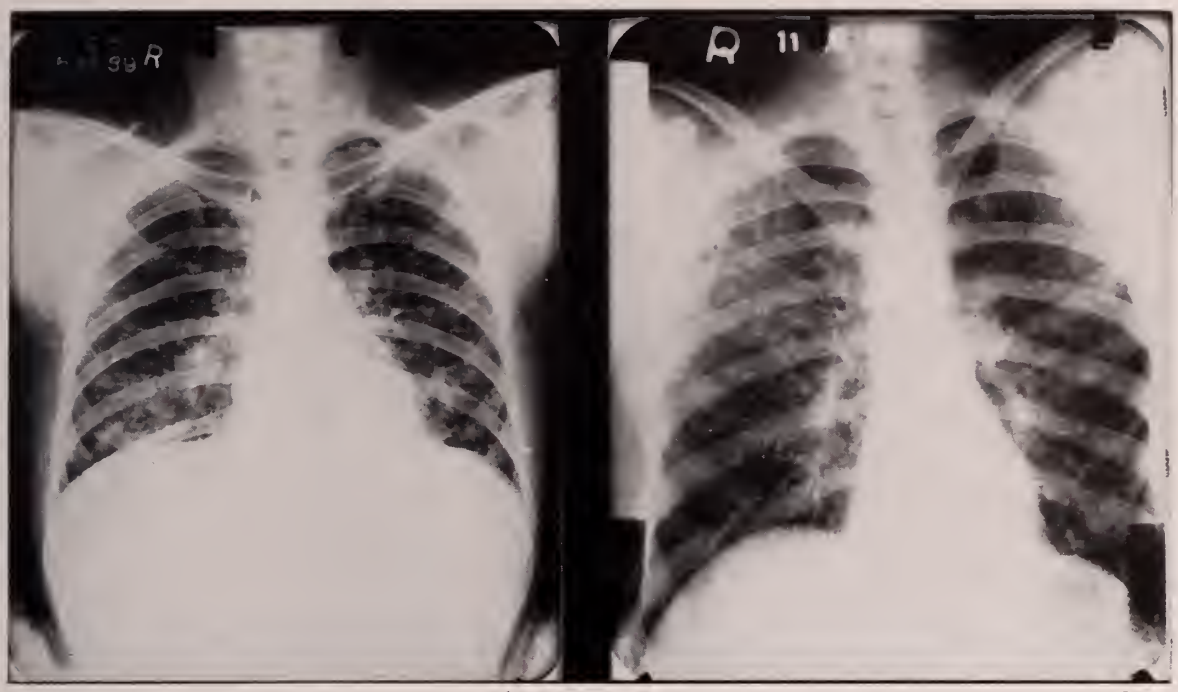
The various conditions diagnosed by each of the procedures are listed in table 2. The nonspecific granulomata listed under scalene nodes were later subjected to pulmonary biopsy which was diagnostic. The 2 cases of nonspecific fibrinous pleuritis are, of course, unsatisfactory from the standpoint of etiology, but a very welcome change from the clinical diagnosis of tuberculous pleural effusion.

In an attempt to better establish the indications for these procedures, we have tried to correlate positive biopsies with specific x-ray findings. We found that in 19 cases in which the radiologist described enlarged hilar nodes, 6, or 31.5%, had positive scalene node biopsies. We further found that of 21 cases showing diffuse pulmonary infiltration, scalene nodes were abnormal in only 5, and 2 of these were not diagnostic. This reduces the diagnostic usefulness to 14% in this type



(a) (b)

Fig. 1—Hilar adenopathy in asymptomatic adults: (a) anaplastic carcinoma; (b) sarcoidosis both proven by scalene node biopsy.

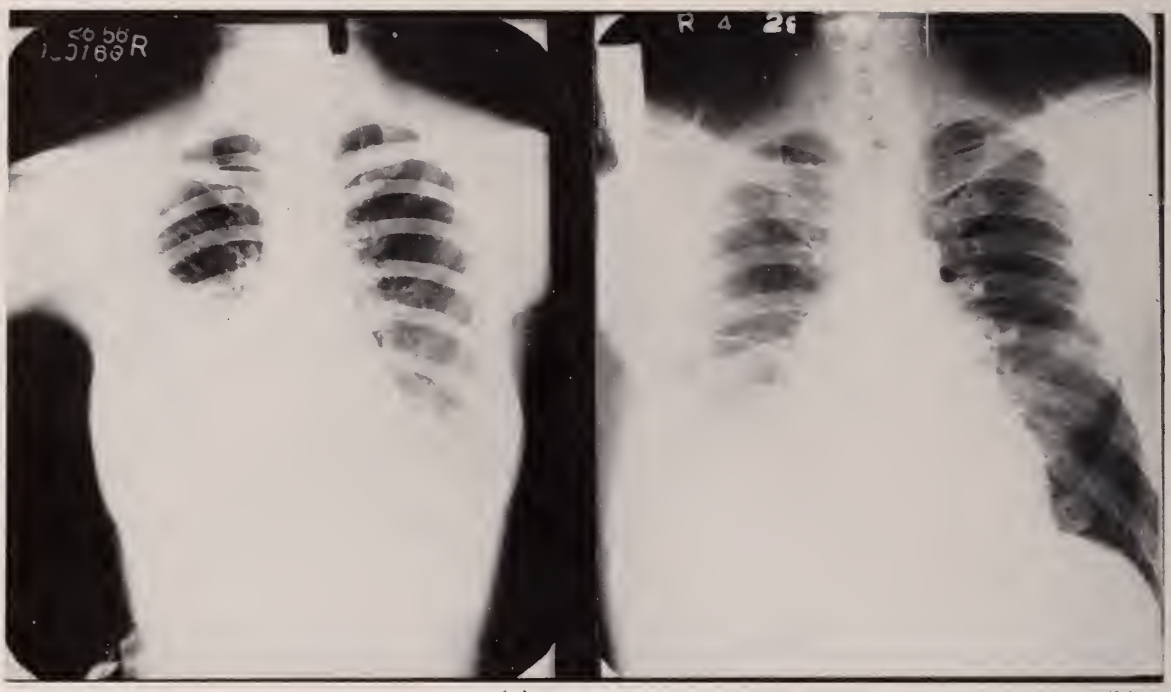


(a) (b)

Fig. 2—Diffuse pulmonary infiltration in young adults with positive histoplasmin skin tests: (a) histoplasmosis; (b) eosinophilic granuloma both proven by pulmonary biopsy.

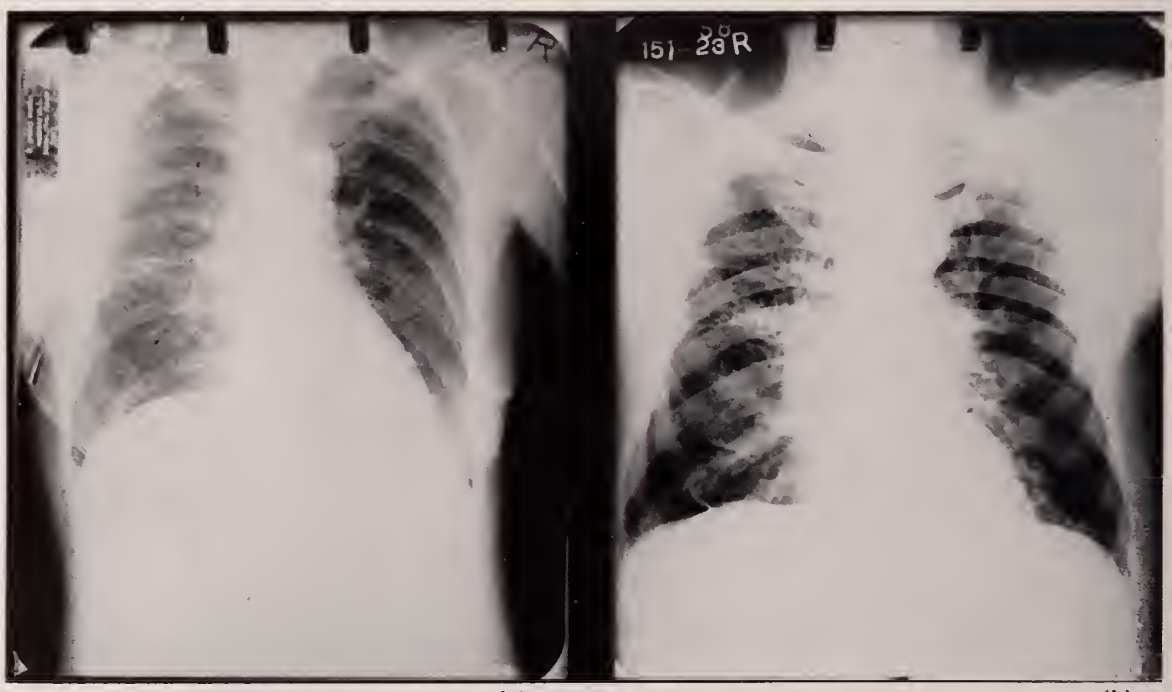
(a) (b)

Fig. 3—Diffuse pulmonary infiltration in two farmers with extensive dust exposure: (a) metastatic carcinoma and (b) farmer's lung proven by scalene node biopsy and pulmonary biopsy respectively.



(a) (b)

Fig. 4—Clear pleural effusion with positive tuberculin skin test: (a) tuberculous pleural effusion; (b) fibrinous pleuritis both proven by pleural biopsy.



(a) (b)

Fig. 5—Unilateral pulmonary infiltration in elderly patients with positive tuberculin skin test: (a) tuberculosis; (b) sarcoidosis both proven by pulmonary biopsy.

of case. Therefore, we have abandoned scalene node biopsy in cases of diffuse pulmonary infiltration in favor of primary pulmonary biopsy. To illustrate the usefulness of the biopsy procedures, paired x-rays are presented in figures 1 to 5. It will be seen that in each pair of cases with similar x-ray findings, the diagnoses are totally different and treatment diametrically opposed.

Conclusions

1. The development of specific therapy for increasing numbers of intrathoracic disease has made mandatory the establishment of histopathologic or microbiologic diagnosis in every case possible.

2. The employment of simple safe biopsy procedures can increase our diagnostic batting average over 50%.

3. With more liberal and logical application of these techniques, further improvement is anticipated.

Marshfield Clinic.

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Summary of an Ectopic Pregnancy*

I. Ninety-five percent (95%) of ectopic pregnancies are tubal.

II. One in every 300 pregnancies will be tubal.

III. There is an unnecessary mortality rate of 3% to 5% where tubal pregnancies exist.

The Solution

I. Be suspicious—Erratic bleeding in a woman of childbearing age means pregnancy or malignancy unless proven otherwise.

II. Every patient should be carefully examined. More damage can be done by no examination than by careful examination—in spite of bleeding.

III. Spotting instead of a period should point the finger of suspicion to ectopic pregnancy.

IV. A hemoglobin lower than consistent with vaginal bleeding should increase suspicion.

V. A unilateral tender mass associated with spotting and a low hemoglobin should require the physician to prove or disprove ectopic pregnancy.

VI. A 16-gauge needle and a 50 cc. syringe for culdocentesis is a valuable—almost certain aid in establishing the diagnosis.

VII. A culdotomy under anesthesia is a second valuable aid.

VIII. When the diagnosis is established, immediate surgery is imperative.

IX. When the ectopic has ruptured and there is shock, IMMEDIATE BLOOD REPLACEMENT UNDER PRESSURE COINCIDENTAL WITH IMMEDIATE SURGERY IS THE RULE.

X. You can save a life by immediate action. You will lose a life if you wait for the patient's stabilization that may never come.

Remember in abdominal pregnancy to permit the placenta to remain intact in the abdomen.

* Presented by F. J. Hofmeister, M.D., Milwaukee, at Maternal Mortality Institutes of the State Medical Society and the Wisconsin State Board of Health at: Racine, January 15, 1959; Sheboygan, January 22, 1959; and Appleton, January 29, 1959.

SPECIAL TO THE JOURNAL

Potential Side-Reactions of Tranquilizing Agents

By W. T. BRUNS, M. D.*
Madison, Wisconsin

The extensive use of tranquilizing agents for a wide variety of diseases as well as for the treatment of many minor symptoms and complaints has been followed by an increasing literature on side-effects of these drugs.[1]

The Poison Information Center at the University Hospitals in Madison, Wisconsin, shares the experience of other centers that tranquilizers are considered by the patient and many physicians to be relatively harmless medications. It appears, therefore, worth re-emphasizing the potential untoward reactions so that they either may be prevented or at least correctly diagnosed and treated.

In 1955, it was estimated that approximately four million persons in the United States were treated either temporarily or by maintenance therapy with tranquilizing agents which at that time was chiefly chlorpromazine. The recommended indications have since multiplied and newer derivatives have been introduced in the attempt to decrease the observed side-effects. This wide distribution is necessarily associated with a higher rate of exposure to dosages exceeding the suggested safe limit, with an increase in accidental ingestion by children, and because of the reputation as "sedating" drugs suicide attempts with tranquilizing agents are not uncommon. (1% of all information calls at our Madison center and according to previous experience at Los Angeles).

The tranquilizing agents which are used at the present time are phenothiazine, meprobramate, reserpine and their combinations and derivates. The number of available commercial products compares with that of the antibiotics.

The phenothiazine group (chlorpromazine, promazine, triflupromazine, mepazine, perphenazine and perchlorperazine) was the first to find an extensive therapeutic application. Jaundice of the intrahepatic obstructive type was initially seen in 1 to 3% of patients treated for more than one week. This side-effect revealed to be transient and responded usually to decrease or discontinuation of dosage. Most of the newer derivates are essentially free of this complication. Agranulocytosis, which is fatal in about one third of the reported cases in the literature, has been observed recently for phenothiazine compounds which were thought not to be toxic for the hemopoietic system. Its occurrence does not seem to be dependent upon the daily or the total dose. There has been observed a variety of allergic skin reactions to phenothiazines which cover the clinical picture from a simple urticaria to bullous or petechial lesions. Their appearance dates typically between the 9th and the 13th day of therapy in 2 to 12% of all treated patients.

The potentiation action of this tranquilizing group, if combined with central nervous system depressants, is of importance not only in regard to medical therapy, but also suicide attempts with tranquilizing agents and alcohol show an identical action.

The so far mentioned complications are, in our experience, better known and easier recognized than the occurrence of excitation of the central nervous system by phenothiazine compounds,[2] although the manufacturers mention the possibility of this side-effect which had been observed mainly in treatment studies at mental institutions. The symptomatology, which is thought to be caused by stimulation of the midbrain reticular formation, consists of several possible findings. The patient may show opisthotonus and generalized spasms, swallow difficulties with gagging movements of the pharyngeal musculature, generalized epileptiform seizures or finally Parkinsonism. Since any combination of these findings may be present, it is not uncommon to witness rather bizarre motor phenomena. Therefore, it is not surprising that diagnoses of bulbar poliomyelitis, encephalitis, meningitis, or even tetanus have been made and that specific treatment for some of these has been initiated. Lumbar punctures have demonstrated normal findings in the limited number of children reported to us in whom this procedure was performed during the acute syndrome. The severity of the neurologic involvement is followed by a fast recovery or discontinuation of the drug, which can be supported advantageously by symptomatic therapy with mild sedation employing short acting barbiturates, possibly ataraxics and intravenous

(continued on page 374)

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Prochlorperazine as a Pre- and Postoperative Adjunct: Report of a Pilot Study with Follow-up

By EUGENE E. ECKSTAM, M. D., F. A. C. S.*

Monroe, Wisconsin

EMOTIONAL REACTIONS and psychomotor agitation that occur before and after surgery are complicating factors which, when severe enough, may actually govern the course of surgery and its eventual outcome. Controlling these reactions and suppressing the nausea and vomiting that is commonly seen postoperatively are difficult and formidable tasks.

Traditionally, either barbiturates or opiates have been used to control pre- and postoperative excitement. However, in recent years the trend has been to reduce or to eliminate the use of these drugs, particularly the opiates, because they exert profound effects on physiologic functions which may be vital to a safe surgical course. Newer drugs—the tranquilizers, chiefly—have been used as adjuncts to the pre- and postoperative regimen because they minimize emotional hyperactivity, potentiate barbiturates and opiates, and control nausea and vomiting without producing significant peripheral or central depressing effects. Two such compounds currently in use are chlorpromazine (Thorazine) and promethazine (Phenergan), both of which are phenothiazine derivatives.

Prochlorperazine† (Compazine), a recently developed phenothiazine, possesses pharmacodynamic properties similar to those of chlorpromazine and promethazine. Pharmacologic studies[1] have revealed, however, that prochlorperazine, produces ataractic, antiemetic, potentiating, and hypotensive effects which are different, either more or less potent, from those produced by its congeners. Because of these interesting differences in pharmacodynamic effects, a pilot study of prochlorperazine was undertaken to determine its value as a preoperative adjunct, and as a postoperative ataractic and antiemetic. The results of this study were also used to determine whether this drug warranted further, more closely controlled investigation.

Method and Material

Fifty-two consecutive patients received varying doses of prochlorperazine preoperatively to control emotional hyperactivity and agitation. Thirty-eight of these patients also received the drug to control postoperative emotional excitement or to suppress nausea and vomiting. The patients ranged in age from 27 years to 77 years; 34 were women and 18 were men. The impending surgical procedures included a variety of extra-abdominal and intra-abdominal procedures, gynecologic and proctologic procedures, and exploratory and reparative procedures. Patients received the drug either orally or parenterally (intramuscularly); 19 patients received it by both routes.

Patients received 15 mg. of prochlorperazine in a sustained release (Spansule) capsule either on admission or at bedtime on the day prior to surgery; (bedtime doses were administered together with three grains of pentobarbital (Nembutal) sodium. Some of the more anxious patients were given 15 mg. of prochlorperazine on admission and at bedtime, along with the barbiturate. Occasionally, a third 15 mg. dose of prochlorperazine in sustained release form was given at 6:00 A.M. on the morning of surgery. The preoperative sedatives were administered intramuscularly 60 minutes before surgery, and consisted of either morphine and scopolamine or meperidine (Demerol) and atropine sulfate. The dose of each of these drugs was determined by the patient's age and weight. The anesthetic agents used were thiopental (Pentothal) sodium, nitrous oxide, and cyclopropane. Ether was used as the anesthetic

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† 2-chloro-10 (-1(1-methyl-4-piperazinyl)-phenothiazine, supplied by Smith, Kline & French Laboratories.

agent in only 8 patients. Succinylcholine (Quelicin) was used routinely.

Postoperatively, when needed, a 10 mg. dose of prochlorperazine was given intramuscularly to control emotional hyperactivity, or to control nausea and vomiting. The tablet form of prochlorperazine was used thereafter as soon as possible. Postoperatively, the dose of prochlorperazine ranged from 10 mg. to 45 mg. per day; the most common daily dose was 15 mg. to 20 mg. Duration of therapy ranged from 1 to 14 days; 41 (79%) patients received the drug for 1 to 4 days.

Results were considered satisfactory when overt symptoms of anxiety, apprehension or psychomotor agitation were controlled and the patient was calm and cooperative on entering the operating room. If the patient exhibited symptoms of agitation when he entered the operating ampitheater, the results were considered unsatisfactory. The postoperative use of prochlorperazine was judged satisfactory when it controlled anxiety, apprehension or restlessness and/or nausea and vomiting. When these symptoms remained uncontrolled, the results were considered unsatisfactory.

Results

The preoperative use of prochlorperazine was judged satisfactory in 44 (85%) of the patients, and unsatisfactory in 8 (15%) of the patients. Postoperatively, when used to control emotional hyperactivity and agitation, prochlorperazine produced satisfactory results in 17 (81%) of the patients, and unsatisfactory results in 4 (19%) of the patients. When used postoperatively as an antiemetic, prochlorperazine controlled nausea and vomiting satisfactorily in 13 (76%) of the patients; 4 (34%) patients did not benefit from the drug.

When the drug had been administered preoperatively, the patients were generally less anxious and tense while being prepared for surgery. When they arrived in the operating room, they appeared to be in a light sleep, but could be aroused easily and would answer questions in a rational manner; when left alone, they would doze again. When aroused, most patients seemed to be aware of their surroundings, but were not apprehensive about their impending operation. The patients in whom unsatisfactory results were observed came to surgery awake and, generally, were those patients who were extremely agitated or nervous on admission. In some of these patients, 2 or 3 days of heavy sedation were required postoperatively to quiet them.

When a single 15 mg. dose of prochlorperazine was administered preoperatively, it was our experience that those patients who received the drug at bedtime were better "sedated" on coming to surgery than were those who received it in the afternoon on admission. On the other hand, we also found that some of the patients who received an evening and morning dose of the drug were too heavily sedated when brought to surgery. We would suggest, therefore, that, in order to obtain maximal benefits, prochlorperazine should be administered, in conjunction with the usual sedation, before bedtime on the night preceding surgery.

Although several of the anesthetists reported that less anesthetic had to be used than was ordinarily the case, it is not clear at this time whether the need for decreased amounts of anesthetic was due to the potentiating effect of prochlorperazine or whether it resulted from an additive effect of the two agents.

Patients who had had previous operations reported that they tolerated the present hospitalization much better. The increase in tolerance to surgery and the hospital routine in these patients was attributed to the preoperative use of prochlorperazine followed by the postoperative use of a maintenance dose (5 mg. q.i.d) of the drug.

Ten (19%) of the patients in this series reported reactions that were classified as side effects. In some instances, however, it was questionable whether the side effects resulted from the use of prochlorperazine or from other drugs which were used pre- and postoperatively. For example, 5 patients receiving doses of prochlorperazine ranging from 15 mg. to 45 mg. per day reported drowsiness, and 3 patients receiving doses ranging from 15 mg. to 20 mg. per day experienced vertigo. Since these patients had received or were receiving barbiturates or narcotics, all or part of the reaction could have resulted from the use of these drugs. In addition to these patients, 1 patient became confused, agitated, and picked at his bedclothes after receiving 10 mg. of prochlorperazine intramuscularly every 6 hours for 3 days. One patient developed respiratory arrest after receiving 15 mg. of prochlorperazine in sustained release form the night before surgery; this patient's reaction will be discussed at length in the comment section. There were

no serious side effects (jaundice, leukopenia, or extrapyramidal symptoms) observed during the evaluation.

Comment

The patient who developed respiratory arrest was a 65-year-old female, who had previously undergone an abdominal hysterectomy with no difficulty. The reaction occurred at the end of an abdominal hernial repair, just as the incision was being closed. On the day before surgery, the patient had received one 15 mg. dose of prochlorperazine in sustained release form and a 3 grain dose of sodium pentobarbital before bed. At 7:00 A.M. on the morning of surgery, she received another 15 mg. dose of prochlorperazine, and at 9:00 A.M. she received 7.5 mg. of morphine sulfate and 0.25 mg. of hyoscine intramuscularly. When she arrived in the operating room at 10:20 A.M., she seemed heavily sedated.

When the respiratory arrest occurred at 11:50 A.M., the patient was carried on manual bag respiration via an intratracheal tube. She was completely flaccid and did not respond to any stimulus such as pin prick, tendon reflex, or anal sphincter dilatation. It was assumed that she had some spasm of the basilar artery of the brain stem. In order to relieve this, two stellate ganglion blocks were performed but were of no value. Intra-arterial (left carotid) procaine administered at 2:15 P.M. relieved the arterial spasm, and within a few minutes the patient was breathing normally and made an uneventful recovery. At the present time, 6 months after surgery, the patient appears normal in all respects.

Whether the respiratory arrest was a direct result of the administration of prochlorperazine or the other preoperative sedatives is not known. It is felt, however, that the arterial spasm was the result of the heavy preoperative sedation caused by the accumulation of the drugs given, and that no one drug alone can be blamed for this episode.

Summary and Conclusions

Based on the results of this pilot evaluation, prochlorperazine appears to be an efficient drug for relieving tension, anxiety and psychomotor agitation commonly seen before and following surgery, and for controlling postoperative nausea and vomiting. Because of the limited number of observations, however, it is believed that a more rigidly controlled, double-blind evaluation of this drug is warranted. Such an evaluation is in progress to further evaluate the use of this drug in controlling preoperative tension, anxiety, and psychomotor agitation. In addition, observations will be conducted to determine the extent of the potentiating and hypotensive effects produced by prochlorperazine.

FOLLOW-UP REPORT

Since the above study was completed, 100 consecutive, unselected adult patients were used in a double-blind study to determine the efficacy of prochlorperazine as previously stated. Supplies were prepared in envelopes containing sustained release capsules of prochlorperazine (15 mg.) or an identical looking capsule of sucrose. The envelopes were marked only with code numbers which were not made available to the investigator until the entire study was completed.

Method

At bedtime the night before surgery the patient usually received approximately 100 mg. of phenobarbital sodium plus a coded sustained release capsule; at 6:00 A.M. an identically coded capsule was given. Approximately 1 hour before surgery meperidine and atropine were administered by subcutaneous injection. The dose of these latter drugs varied according to the patient's age and weight.

Results

Table 1 shows the results obtained with prochlorperazine and the placebo in controlling preoperative anxiety. Although slightly more favorable results were obtained with prochlorperazine than with the placebo, the difference between the results are not statistically significant. A comparison of the results obtained with prochlorperazine in the pilot study (85% satisfactory response) with those obtained in the double-blind study

TABLE 1—PREOPERATIVE USE OF COMPAZINE FOR ANXIETY

Degree of Anxiety	RESULTS							
	Compazine				Placebo			
	Excell.	Good	Fair	Poor	Excell.	Good	Fair	Poor
Mild	17	11	3	3	17	7	5	6
Moderate	5	4	3	2	2	3	3	4
Severe	1	0	0	1	1	0	1	1
TOTALS	23	15	6	6	20	10	9	11

TABLE 2—POSTOPERATIVE USE OF COMPAZINE FOR NAUSEA AND VOMITING

Preoperative Medication	No. of patients treated preop.	No. of patients treated for N. & V.	Results			
			Excell.	Good	Fair	Poor
Placebo	50	28	13	5	5	5
Compazine	50	19	7	4	5	3
TOTALS	100	47	20	9	10	8

TABLE 3—TIME OF OCCURRENCE OF POSTOPERATIVE NAUSEA AND VOMITING

Preoperative Medication	No. of patients treated preop.	No. of patients having N. & V.*	Time of Occurrence in Hours						
			0–2	2–4	4–6	6–8	8–10	10–12	longer **
Placebo	50	41	20	8	6	1	1	2	3
Compazine	50	29	7	9	5	2	4	1	1
TOTALS	100	70	27	17	11	3	5	3	4

*Only 47 patients required treatment with Compazine.
**From 13 hours to 5 days.

(76% excellent or good response) indicates a difference of 9%. One reason for this difference may have been due to the fact that only meperidine was used as a preoperative narcotic in the double-blind study, whereas morphine sulfate, a more potent sedative, and hyoscine (1/260 gr.) which also has sedative and antiemetic effects was usually administered in the pilot study. Accounting for the high degree of effectiveness of the placebo (60% excellent or good response) in the double-blind evaluation is difficult. According to Beecher,[2] who has investigated the use of placebos extensively, average placebo effect is rarely more than 35%, regardless of the indication being treated. Although our results with the placebo are higher than would be normally expected, they could, nevertheless, be within the realm of placebo effect. However, since over two-thirds of the patients had only mild preoperative anxiety, one could argue that they probably didn't require medication and shouldn't have been chosen for the evaluation. That this might be so is partly evidenced by the fact that a statistical test of the results obtained with prochlorperazine and the placebo in patients with moderate or severe anxiety is very close to being significant in favor of the active drug. In any case, the results of double-blind evaluation serve to point up why results based on uncontrolled observations should be avoided whenever possible.

Table 2 shows the effect of prochlorperazine in controlling postoperative nausea and vomiting. The results here are statistically significant, and it shows a lesser incidence of nausea and vomiting in patients treated with prochlorperazine than in those treated with a placebo.

Table 3 illustrates the time of occurrence of postoperative nausea and vomiting. Although it might appear that more of the placebo patients vomited sooner, actually according to statistical analysis, they are very close to being the same.

It should be re-emphasized, however, that the type of narcotic sedation should be changed when postoperative nausea and vomiting occur. Even if the narcotic responsible for nausea and vomiting is not changed, prochlorperazine will help to allay the nausea and vomiting but will not completely relieve it.

Side Effects

One patient, who received a placebo preoperatively and 100 mg. of prochlorperazine postoperatively for nausea and vomiting developed a postoperative manic psychosis and required several different types of sedatives before this was brought under control. This patient was rather "flighty", and I do not believe that prochlorperazine had any effect in producing this manic psychosis.

Thirty-three of the 100 patients developed some degree of hypotension after surgery, and this was almost equally divided between the patients receiving prochlorperazine (18) and those receiving the placebo (15).

Of the 15 patients who received the placebo, 11 had received prochlorperazine postoperatively for nausea and vomiting. However, in nearly all of the patients, hypotension was noted before the administration of prochlorperazine. Therefore, I do not believe that prochlorperazine has any effect on the production of postoperative hypotension when given in this manner.

Summary

A double-blind study has shown that prochlorperazine used before surgery in an effort to allay preoperative anxiety was only slightly better than a placebo. The preoperative use of prochlorperazine definitely reduces the postoperative incidence of nausea and vomiting. There were no side effects attributable directly to prochlorperazine in the double-blind study.

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Hidden Lesions of the Sigmoid Colon

By MARVIN E. SATTLER, M. D., and ROBERT W. MANN, M. D.

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LESIONS OF THE SIGMOID colon are frequently obscured through anatomical peculiarities of this segment of the bowel. The most painstaking x-ray examinations will miss the lesions in 5% to 10% of colons thus examined.[1] The sigmoidoscope also fails to visualize lesions in certain multi-coiled sigmoids.

This is not to be construed as criticism of the roentgenologist or examining proctologist because the redundant and often coiled sigmoid colon will obscure some areas even if all possible diagnostic means are used. In doubtful cases, the radiologist uses the lateral, oblique, angle oblique, angle anteroposterior, and the Chassard–Lapine positions to demonstrate hidden lesions of the sigmoid colon.[2]

It is often very difficult to localize lesions by sigmoidoscopy. Deddish and Fairweather[3] have suggested the use of a sterile sigmoidoscope to localize hidden lesions during exploratory laparotomy. This is another procedure which has been placed in the armamentarium of the surgeon.

The following reasons are mentioned by Bockus[4] for the difficulty in localizing lesions by sigmoidoscopy:

1. The recto sigmoid junction physiologically contains a sharp angulation.
2. The caliber of the lumen of the bowel at this level is markedly reduced.
3. There is a sphincter at this level (sphincter of O'Berne or Moutier).
4. The mucosa of the sigmoid is thrown into prominent rugal folds in which lesions can be hidden.

The incidence of carcinoma in the rectosigmoid is high. Most statistics place 70% of all malignancies of the colon in this area. Of these, 20% to 30% lie in the sigmoid colon. These statistics indicate that the incidence of missed lesions is probably higher than we had previously realized.

The sigmoid colon is defined by Shackelford[5] as follows: "The sigmoid colon is that part of the colon between the descending colon and the rectum. It begins at the brim of the pelvis and ends at the sigmoid-rectal junction which is at the level of the third sacral vertebrae and is the point at which the peritoneal investment and mesentery of the sigmoid cease. It is divisable into a fixed (iliac) and a mobile (pelvic) segment. The portion of the sigmoid colon in which lesions are most apt to be overlooked is that which has been defined as the pelvic or mobile segment. This segment or division of the sigmoid is a long, omega-shaped coil of bowel which is continuous above with the iliac colon and below with the rectum."

It is well known that surgeons dislike exploring an abdomen for a lesion of the colon without specific information gained by the methods previously mentioned. We must consider exploratory laparotomy where clinical evidence of a lesion exists even though x-ray and sigmoidoscopic examination are negative. It is obvious that with our present knowledge of cancer, the only chance for cure lies with early diagnosis and removal. We must not consider exploratory laparotomy too radical an approach in many of these cases.

The following two cases are examples of prolonged periods of observation and reexamination which failed to bring to light the actual source of bleeding.

Case 1—A 54-year-old white male entered the hospital complaining of blood in the stool which had been noted for almost two years. It was small in amount, bright red, usually on the surface of the stool. He had pruritis ani for many years and was told that this was the cause of bleeding. Bowel function was otherwise entirely normal. There was no weight loss. Sigmoidoscopic examination was reported as negative 15 months prior to this examination. X-ray with barium enema at the same time showed no evidence of organic disease of the colon. Six months prior to this admission, the patient had seen a second physician and sigmoidoscopy and x-rays were repeated. The x-rays were still reported as negative, but three polyps were found, approximately 17 cm. from the anus. These had been

Fig. 1—X-ray of one of many views and films taken of patient in Case 1 with negative results.

removed and the microscopic report from the pathologist was "noninvasive carcinomatous polyp of the rectum".

The patient was admitted again eleven months later. At this time, he stated that he had still noted a small amount of bright blood on the surface of the stool. Sigmoidoscopic and x-ray examinations were repeated and reported negative. The patient then left the city and went to a clinic where another complete examination was done. They reported negative x-rays and sigmoidoscopic examinations, but after repeated stool examinations, believed they had found amebiasis. He had been placed on a course of emetine hydrochloride and thought that the bleeding had stopped somewhat. One month later, however, he began to notice the same small amount of blood in the stool. At this time, the x-ray of the colon showed the following:

> "Examination on two separate occasions showed the presence of a small deformity and defect of the inferior wall of the sigmoid colon. This deformity is fairly constant and measures approximately 2 cm. in diameter."

At surgery, a lesion measuring about 3 cm. in diameter invading through the muscularis with definite diagnosis of adenocarcinoma was found. A wide resection was done. The entire remaining colon was examined both by palpation and colotomy, using a sigmoidoscope. (Fig. 1 and 2).

Case 2—A 60-year-old, white female entered the hospital stating that she had been perfectly well until eleven months previously. At that time she noted some change in bowel habit, mainly an unusual constipation. She noted a very small amount of bright red blood mixed with mucus which was seen on the surface of the stool. A careful analysis of her work-up is as follows:

April 28th, complete examination including rectal and sigmoidoscopic examination was negative.

Fig. 2—Definite lesion present in the sigmoid colon, 28 months after the initial negative examinations, of patient in Case 1.

May 5th, x-ray with barium enema, no definite abnormality noted, but re-check advised.

May 27th, possible small filling defect in the sigmoid on x-ray examination, re-check indicated.

June 1st, no constant defect was demonstrated and the impression was that no organic defect was present.

June 12th, the patient saw other consultant and further x-rays were done. No definite abnormality was found, re-check in one month was advised.

July 12th, normal sigmoid colon on x-ray with barium enema, continued observation advised.

October 20th, sigmoidoscopic examination, x-ray with barium enema negative, continued observation advised.

December 12th, the patient now saw another physician and she was again hospitalized. There was still occasional flecks of blood on the stool, but no weight loss or evidence of generalized disease. One additional symptom, slight discomfort in the left upper quadrant, appeared. X-ray examination of the colon by the same roentgenologist who had given the original report showed now a suspicious lesion as follows:

> "Persistent defect in the sigmoid colon; it measures approximately one inch in length."

Fig. 3—Oblique view of the sigmoid colon showing a suspected lesion. After two further examinations, the lesion could not be demonstrated. This patient in Case 2 was further examined on three more occasions and no pathology found.

Fig. 4—Barium enema x-ray on re-entry to the hospital seven months after the initial examination of patient in Case 2. This film revealed a definite constricting lesion in the sigmoid colon.

The patient was now referred to us for surgical consultation. She was prepared for bowel surgery and an exploratory laparotomy performed. A small tumor of the redundant portion of the sigmoid colon was found, measuring 2.5 cm. in diameter. Large glands were noted along the pre-aortic chain and a huge metastasis involving the entire left lobe of the liver was present. This apparently had given her the left upper quadrant symptoms which she had complained of on this last admission. (Fig. 3 and 4).

Discussion

The cases presented are just two of the extreme examples of prolonged observation in patients who have blood in the stool. We have reason to believe, however, that this is not an uncommon practice and that we are frequently delaying treatment in a patient who might be favorably treated in the early stages of the disease. Exploratory laparotomy should not be considered so hazardous a procedure as to await absolute diagnosis in these instances. There is reluctance by both internist and surgeon frequently to attack these diagnostic problems surgically. The patient who has blood on the stool and has had a thorough work-up including sigmoidoscopic and x-ray examination with barium enema without finding a source of bleeding, should be considered a candidate for exploratory laparotomy, after a short period of observation and having had the diagnostic studies repeated.

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Chest Disease Film of "Grand Rounds" No. 8

A limited number of 16mm. sound Kinescope (films) of Upjohn's eighth "Grand Rounds" closed-circuit television program, "Clinical Problems in Chest Disease: Hemoptysis, Pneumonitis, the Mediastinal Mass, Pleural Effusion with Special Reports on Pulmonary Cytology and the Management of Chest Trauma," are available through Upjohn or its representatives. Showing time is 90 minutes.

Applications for Research Support Now Being Accepted by AHA

Applications are now being accepted by the American Heart Association for support of research to be conducted during the fiscal year beginning July 1, 1960, according to the Wisconsin Heart Association.

September 15, 1959 is the deadline for applying for Research Fellowships and Established Investigatorships. Applications for Grant-in-Aid must be made by November 1, 1959.

Public contributions to the annual Heart Fund campaign provide the funds for Association-supported research. Support is given not only to studies with a direct bearing on problems of cardiovascular medicine but also to basic research in a wide range of scientific disciplines. The Association recently announced its national awards for the 1959–60 fiscal year, representing an allocation of approximately $3,300,000.

Following are brief accounts of the categories in which applications may be made:

Established Investigatorships: Awarded for periods of up to five years, subject to annual review, in amounts ranging from $6,500 to $8,500 yearly plus dependency allowances, to scientists of proven ability who have developed in their research careers to the point where they are independent investigators. In addition, a grant of $500 is made to the investigator's department. Applicants for Established Investigatorships may apply for grant-in-aid to support their research at the same time they apply for Established Investigatorships.

Advanced Research Fellowships: Awarded for periods of one or two years to post-doctoral applicants who have had some research training and experience but who are not clearly qualified to conduct their own independent research. During the second year of tenure they will be permitted to spend up to 25 percent of their time in professional and scientific activities not strictly of a research nature, provided that these will contribute to their professional development and do not involve services for a fee. These stipends range from $4,600 to $6,500 annually. Additionally, a grant of $500 is made to the investigator's department, as in the case of Established Investigators.

Research Fellowships: A limited number of awards are available to young men and women with doctoral degrees for periods of one or two years to enable them to train as investigators under experienced supervision. Annual stipends range from $3,800 to $5,700.

Grants-in-Aid: Made to experienced investigators to help underwrite the costs of specified projects, such as equipment, technical assistance and supplies.

Further information and application forms may be obtained from the Assistant Medical Director for Research, American Heart Association, 44 East 23rd Street, New York 10, N. Y.

A & R Foundation Offers Investigatorship Awards

The Arthritis and Rheumatism Foundation offers predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1960. Deadline for applications is October 31, 1959.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

The program provides for three awards:

(1) *Predoctoral Fellowships* are limited to students who hold a bachelor's degree. Each applicant studying for an advanced degree must be acceptable to the individual under whom the work will be done. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from $1500 to $3000 per year, depending upon the family responsibilities of the Fellow.

(2) Postdoctoral Fellowships are limited to applicants with the degree of Doctor of Medicine, Doctor of Philosophy—or their equivalent. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from $4000 to $6000 per year, depending upon the family responsibilities of the Fellow.

(3) *Senior Investigator Awards* are made to candidates holding or eligible for a "faculty rank" such as Instructor or Assistant Professor (or equivalent) and who are sponsored by their institution. Stipends are from $6000 to $10,000 per year and are tenable for five years.

A sum of $500 will be paid to cover the laboratory expenses of each postdoctoral fellow and senior investigator. An equal sum will be paid to either cover the tuition expenses or laboratory expenses of each predoctoral fellow.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

Sponsored by Section on Pathology
State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Prolonged Survival Following Bilateral Renal Cortical Necrosis

Guest Editor: ROBERT S. HAUKOHL, M. D.*
Milwaukee, Wisconsin

Case Presentation

The patient was a 74-year-old, unmarried, white woman who was knocked down by an automobile on September 26, 1958. It was said that there was momentary loss of consciousness. She was taken to Milwaukee County General Hospital where examination revealed multiple contusions but no fractures. While under observation there, she suddenly developed profound peripheral vascular collapse but recovered within a short time after receiving one unit of whole blood. Progressive oliguria became manifest shortly after this episode, but she was otherwise considered to be in satisfactory condition for transfer to Evangelical Deaconess Hospital. At the time of transfer she was oliguric and nauseated and complained of pain in the lower abdomen, flanks, buttocks, and extremities, especially on the left side. There was no history of previous serious illnesses.

PHYSICAL EXAMINATION: The patient was well-developed, well-nourished, and conscious, cooperative, alert, and well-oriented. The blood pressure was 190/90, temperature, 100.6 F., pulse rate, 110/min., and respiratory rate, 24/min. Multiple contusions were noted over the left supraorbital area, right ear, and left lumbar area. An irregular hematoma, 8 to 10 cm. in maximum dimension, was present over the lumbar area and tenderness was present over the lumbosacral and left iliac regions. The cardiac rhythm was normal but a soft, apical systolic murmur was audible. Auscultation also revealed a few, moist, basilar rales.

ROENTGENOLOGIC FINDINGS: An admission chest film showed cardiac enlargement and increased pulmonary markings compatible with congestive failure. A flat plate of the abdomen on October 14 demonstrated no abnormalities. Two retrograde urograms (September 29 and October 28) were normal.

CYSTOSCOPIC FINDINGS: Two cystoscopic examinations combined with uretheral catheterizations in conjunction with the urograms revealed no anatomical abnormalities or evidence of mechanical urinary obstruction.

ELECTROCARDIOGRAPHIC FINDINGS: October 1 and 5—within normal limits; October 21—marked T and ST wave changes suggestive of myocardial change (recent coronary occlusion, anemia, etc.); October 23—first degree heart block; nonspecific T and ST wave changes (digitalis); October 31—no change; November 11—nonspecific T and ST wave changes; supraventricular tachycardia, type undetermined.

LABORATORY FINDINGS: On admission, urine—insufficient volume for specific gravity determination, 4-plus albuminuria, packed with red blood cells and white blood cells, no casts; blood—12 gm. hemoglobin, 35% hematocrit, 21,500 white blood cells. Thereafter, urine specimens showed specific gravity readings between 1.003 and 1.010, 1-plus to 4-plus albumin, red blood cells and white blood cells ranging from none to many and no casts, except on one examination when occasional granular casts were found. The hematocrit percentage fluctuated between 18 and 32. (Blood NPN, CO_2-content Na, K and Cl levels are presented graphically in figure 1, and urinary excretion of Na, K and Cl correlated with total 24-hour urine volumes is similarly summarized in figure 2.)

* From Evangelical Deaconess Hospital and Department of Pathology, Marquette University School of Medicine, Milwaukee.

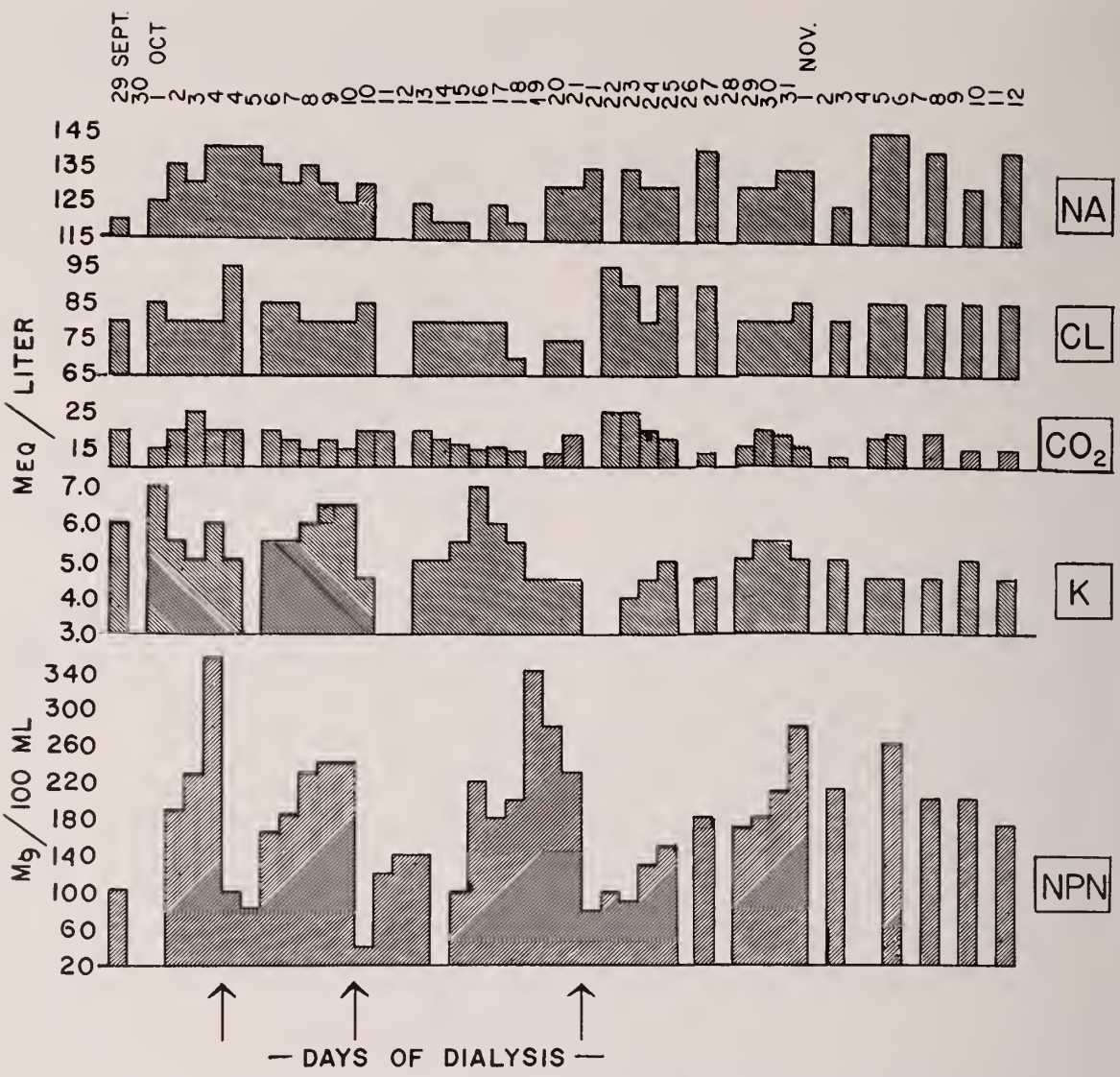

Fig. 1—Composite graphic representation of blood levels of NPN, K, NA, CL, CO_2 content showing effects of dialyses.

Dialysis Data: October 4—duration, 7 hours; pH of dialysant, 7.30 to 7.65; hematocrit, 18 to 24%. October 10—duration, 7 hours; pH of dialysant, 7.30 to 7.65; hematocrit, 18 to 22%. October 21—duration, 6½ hours; pH of dialysant, 7.49 to 7.80; hematocrit, 18 to 22%.

Course in Hospital: The initial phase of anuria and oliguria which extended to October 18 was characterized mainly by extreme lethargy, occasional nausea and frequent complaints of pain in the abdomen and left side of the body. Momentary alertness followed the first dialysis but she again lapsed into a state of lethargy. Following the second dialysis not much improvement in her general condition was noted until the third post-dialysis day when she again seemed more alert. However this, too, was short-lived. On October 14, she began having abdominal distention with discomfort, increasing edema and lethargy. On October 18, she had, for the first time since her accident, a 24-hour urine output of over 350 ml. The urinary volume gradually diminished again after the third dialysis and for 5 days between October 21 and 26 she had a maximum daily output of only 50 ml. After this period, there was a period of relative diuresis during which a maximum urinary volume of 800 ml. was reached. In spite of the increasing urinary output she started to

deteriorate, manifesting increasing lethargy and edema, diarrhea, and eventually marked belligerence and an uncooperative attitude. Although there were occasional short cheerful moments, she eventually developed respiratory difficulties with cyanosis terminally and died on November 13, 1958.

Discussion

Dr. James Means: This case presents an instructive and interesting differential diagnostic problem. All three groups of causes of acute anuria must be considered, *i.e.*, renal, prerenal and postrenal. The possibility also exists that the patient had an underlying chronic renal disease with acute anuria superimposed.

This patient was severely traumatized in an auto accident, exhibited extensive muscle injury and hemorrhage into back muscles, developed shock, was given blood, and passed grossly bloody urine before she became completely anuric.

In the *postrenal or obstructive* type of anuria one must consider that the ureters could have been severed, a large pelvic hematoma could be kinking the ureters and obstructing them, the ureters could be blocked by blood clots from severely traumatized kidneys, or the ureters could be occluded by edema and swelling secondary to trauma. Doctor Marquardt has eliminated most of these causes by his studies.

In the *prerenal category*, one has to consider shock with fluid, blood, and electrolyte losses as a cause. Any defect here had been corrected before the patient arrived at this hospital. Certainly, in a 74-year-old patient, there is some arteriosclerosis. During the severe trauma to the back, the renal arteries may have been damaged, or an arteriosclerotic plaque shaken loose. In the post-traumatic state thrombi form more readily and acute renal artery thrombosis must be considered. This may be eliminated because as time progressed urine did flow. Multiple emboli to the kidneys must be considered but may be eliminated on the basis that no other evidence of embolic phenomena existed. Trauma to both kidneys with intracapsular hemorrhage may be only ruled out by percentages in spite of the fact that the psoas shadows were not seen on roentgenographic studies of the urinary tract.

This brings us to the *renal causes* of acute anuria which include nephrosis of the hemo-

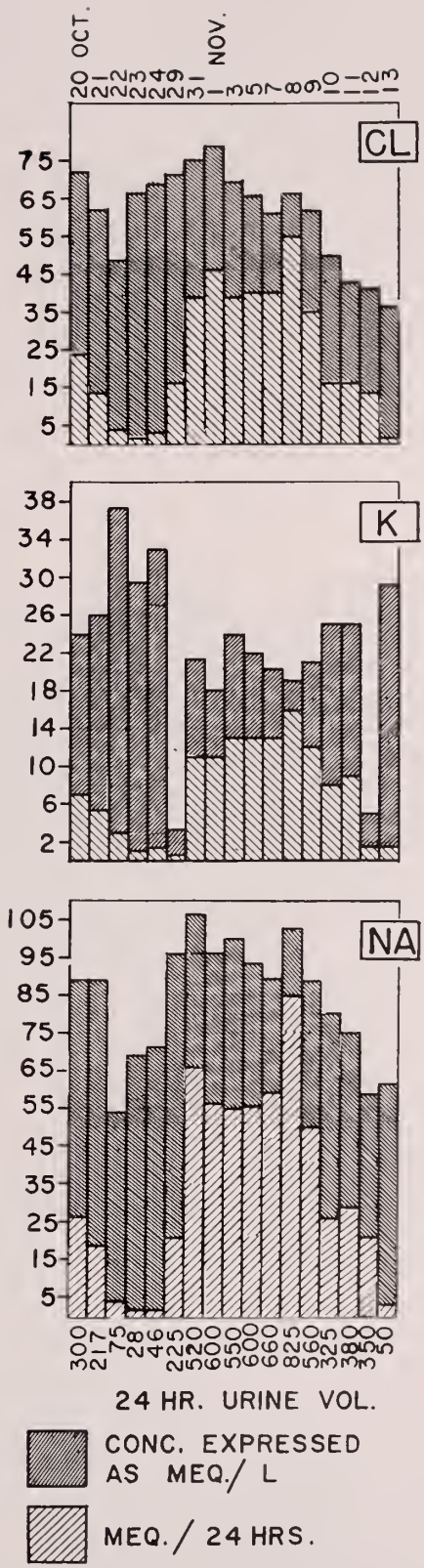

Figure 2

globinuric, myoglobinuric or toxic types, acute cortical necrosis, and severe renal infections. Infections may be eliminated by the absence of fever and bacilluria in this case as well as the prominent pyuria seen in acute necrotizing papillitis. Acute glomerulonephritis may be eliminated by the lack of a characteristic history. Arteriosclerotic nephrosclerosis may not be dismissed entirely; however, it in itself does not cause acute anuria. This brings us to nephrosis sometimes erroneously called lower nephron nephrosis. The patient was given blood while in shock following her injury and was stated to have passed bloody urine after the transfusion. The blood crossmatch, however, was compatible and she did not exhibit a temperature rise, rash or other signs of a transfusion reaction. When one sees a massive hematoma covering the entire back, and feels edematous muscles, one must think of the crush syndrome with myoglobinuric nephrosis. These findings were present and in my mind would represent the major cause of the anuria. Acute cortical necrosis is usually seen in obstetrical patients associated with premature separation of the placenta, liver failure, or severe toxicity and shock. Acute cortical necrosis may occur in other conditions in either sex but is rare, its exact cause is unknown, and it may be differentiated from nephrosis only by the fact that gross hematuria persists for a longer period. If cortical necrosis alone exists, the hemoglobin and/or myoglobin casts are not the major urinary findings. In this case, there are not a sufficient number of microscopic descriptions of the urine to completely eliminate this as a cause. This, however, should be dismissed on a percentage basis. My final diagnosis in this case would have to be nephrosis of a myoglobinuric and possibly hemoglobinuric type, the hemoglobin coming from the massive hematoma rather than a transfusion reaction.

Before closing this discussion, I wish to say a few words about the clinical management of this case. In a case of anuria, it is extremely important to keep the fluid intake low. Under most circumstances 750 to 1,000 cc. per day are adequate. Although the status of the patient's hydration may be followed by intake and output, appearance of edema, and the evaluation of hematocrit, a more accurate method is to weigh the patient daily. This patient's clinical status did not permit this being done. A bedside hammock scale, however, if available may be used to great advantage in such cases.

The diuretic phase of nephrosis presents somewhat of a clinical problem. The patient usually loses large amounts of water and salt without a drop in the nonprotein nitrogen. It is essential to replace the electrolytes and fluid losses during this period and to keep ahead of them until the blood nitrogen is about normal and salt is again selectively excreted by the kidney.

The indications for dialysis are multiple and sometimes even confusing to the physicians handling the case. Before considering dialysis one must always eliminate other causes of a patient's deterioration. Pneumonia and secondary infections may confuse the issue and also kill the patient. A cerebral vascular accident and coronary thrombosis may occur in an older patient. Of the uremic causes, potassium intoxication has, in the past, been considered the most urgent indication for dialysis. Today, however, there are three ways of handling this problem. For short-term correction of hyperkalemia, while the kidney is being prepared, glucose and insulin or molar sodium lactate is quite efficient in eliminating the cardiotoxic elements. Potassium absorbing resins by mouth or small retention enemata may also control the potassium for extended periods. Today the nonspecific disturbing signs of uremia present the major indications for dialysis. Uremic pericarditis with anterior chest pain and a to-and-fro friction rub, uremic colitis with bloody diarrhea and loss of fluid and electrolytes in unknown quantities, uremic pneumonitis, uremic coma, severe acidosis with very low carbon dioxide, heart failure, and clinical failure of the patient with no other evident cause are the major indications for dialysis. These signs usually mean that dialysis must be started within 24 hours. It is also better to err on the early side than to postpone dialysis to the bitter end. The procedure is actually past the experimental stage and carries less risk than most surgical procedures. The last dialysis in this patient was either postponed too long or the patient developed a cerebral hemorrhage or thrombosis while on the artificial kidney to account for her post-dialysis mental state. If this had not developed, I believe that a fourth dialysis might have enabled her to recover sufficient renal function to support life. The fact that

she never developed the diuretic phase makes one wonder about the diagnosis of nephrosis as the single cause of the renal failure. Therefore, my final diagnosis is nephrosis of the myoglobin and hemoglobin type superimposed on a severely arteriosclerotic kidney. Cortical necrosis cannot be ruled out except on a statistical basis and the fact that the patient was not ill before her injury. However, even if it were present, the treatment would have been the same. Merrill and his group have reported cases that have recovered. A needle biopsy of the kidney might have allowed a diagnosis before death.

Post Mortem Findings

Dr. Robert S. Haukohl (Pathologist): The autopsy was performed seven hours after death. External examination was not striking. The significant findings included an increased antero-posterior diameter of the chest with kypholordosis. Dependent edema was not prominent. A large decubitus ulcer was present over the sacrum. The mouth and oral pharynx were filled with gastric contents. There were innumerable venous cut down and venipuncture wounds scattered over all four extremities.

The body was open through a Y-type incision that extended beneath the breasts. The abdominal cavity contained about 300 cc. of clear straw-colored fluid and an estimated 300 cc. of clear fluid were present in either pleural cavity. Moderate to marked atherosclerosis was apparent of the coronary and renal arteries and of the aorta. The heart showed no other disease. Both lungs were massively edematous, the right weighing 780 gm. and the left 440 gm. Considerable quantities of frothy fluid could be expressed from the cut surfaces and in some of the larger bronchi this fluid was of a green and brown color suggesting gastric content. The spleen, liver, pancreas and the gastrointestinal tract showed no significant change. The adrenals presented rather thin and dark colored cortices. The internal genitalia and the lower urinary tract were without significant gross change.

The remarkable autopsy findings in this case were present in the kidneys. The right kidney weighed 85 gm. and the left, 105 gm. The capsule bilaterally stripped away easily revealing a smooth but rather bosselated-appearing, grayish brown, external surface. The cut surfaces (fig. 3) were predominately of a dark brown color with prominent brown streaking of the medullary pyramids. The parenchyma averaged 17 mm. in thickness but of this, only one or two millimeters represented cortex. The cortex whether seen peripherally or between the pyramids presented a mottled appearance. A few serpiginous zones of bright or dark yellow soft tissue were seen alternating with small hemorrhagic areas. The large and medium-sized renal vessels stood out prominently from the cut surface and showed evidence of arteriosclerosis. There was no persisting evidence of the trauma which occasioned this patient's admission. Both external and internal examination of the paravertebral soft tissues showed no persisting evidence of hemorrhage.

Fig. 3—Photograph of the cut surface of the kidney. The marked cortical thinning with foci of necrosis and hemorrhage is apparent. The medullary pyramids appear normal.

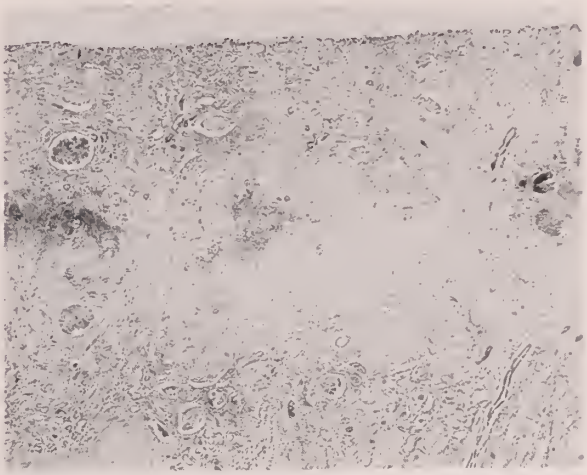

Fig. 4—Photomicrograph of kidney cortex showing marked atrophy with necrotic and hemorrhagic foci. The juxtamedullary tissues however are well preserved.

Other than for marked pulmonary edema and the aspiration of gastric content, the remarkable microscopic findings in this case were confined to the kidneys. Here there was marked and diffuse cortical thinning with the central portion of the cortex showing areas of ischemic necrosis and zones of diffuse hemorrhage both into the interstitial tissue and the few persisting shadows of tubules and glomeruli (fig. 4). The tissues of the pyramids were reasonably well preserved although the tubular epithelium in many places was desquamated and many tubules contained heme casts. A narrow zone of fairly well preserved renal cortical tissue could be found in a juxtamedullary situation as well as immediately beneath the capsule. Here a few persisting glomeruli showed moderate arteriosclerotic alteration. The small and medium-sized renal arteries showed moderate arteriosclerotic narrowing.

The principal post mortem findings may be listed as:

1. Bilateral renal cortical necrosis and atrophy secondary to diffuse cortical necrosis (48 days).
2. Hydrothorax and ascites.
3. Aspiration of gastric content with marked bilateral pulmonary edema.
4. Generalized arteriosclerosis with aortic, coronary and renal arteriosclerosis.

Discussion

Doctor Haukohl: This case represents the first recorded proven instance of prolonged survival following bilateral renal cortical necrosis. If we assume that the patient's episode of cortical necrosis occurred shortly after the initial trauma, and the ultimate renal changes would suggest this, we have a case that survived for 48 days. By the time of autopsy, the thickness of the renal cortex had decreased 3 or 4 fold and only a few persisting areas of hemorrhage and necrosis could be found. This condition is usually seen at autopsy and in a much more acute stage. The renal cortex is normal or occasionally increased in thickness because of swelling and hemorrhage. The patients usually survive only 6 to 12 days after the onset of renal failure. Although the first case of renal bilateral cortical necrosis was described in 1886 by Juhel–Renoy, only 71 cases of this malady had been reported by 1941 when Duff and More reviewed the literature. The disease occurs predominately in young women during pregnancy. A few cases have been reported secondary to a variety of nephrotoxic agents or associated with burns, shock and a variety of infections.[1] The precipitating cause in the case under discussion no doubt was an episode of shock following the injury. This disease would appear to represent and bear out the experimental work of Trueta[2] and his associates in rabbits. These investigators were able to demonstrate that the crushing of the muscles of an extremity, stimulating the sciatic nerve or the injection of vasopressin (Pitressin) is followed in the rabbit by ischemia of most of the renal cortex and marked hyperemia of the juxtamedullary glomeruli and the medulla. This eventuated in symmetrical cortical necrosis. They concluded that an appropriate neural stimulus caused a diversion of blood from the outer zones of the renal cortex through juxtamedullary glomeruli and back to the systemic circulation, leaving the outer zone of the cortex relatively bloodless. The anatomic findings in bilateral renal cortical necrosis would appear to substantiate this theory except that in human cases marked hyperemia of a narrow zone of renal tissue is also seen in the subcapsular area. This might be explainable on the basis of the relatively rich vascular supply which the outer cortex receives from the renal capsule itself.

This rather unexpected anatomical finding superimposed on a moderate degree of arteriosclerotic nephrosclerosis would seem to indicate that the heroic measures of dialysis were destined to be of no material assistance to this patient from the onset. There is no positive evidence in the literature that patients have ever survived massive bilateral renal cortical necrosis. A number of instances of such recovery are recorded but proof is lacking that the clinical picture was not simulated by some other renal lesion such as hemoglobinuric nephrosis. The repeated dialysis on the other hand did allow us to see a kidney 48 days following cortical necrosis, an experience which I believe is unique.

Dr. Yoshiro Taira: The presentation of certain clinical laboratory data in a graphic form as in figure 2 brings out some other interesting aspects of this case. The most conspicuous feature is the wide fluctuations in urinary potassium concentrations with relatively stable concentrations of urinary

sodium and, particularly, chloride. Closer scrutiny further reveals that the highest urinary potassium concentrations, expressed in mEq./L. occurred during the three-day period immediately after the third dialysis when the 24-hour urine volumes were lowest. During the same period, the concentrations of the other two electrolytes, on the other hand, shifted or tended to shift in the opposite direction. Then, with the appearance of relative diuresis, the urinary potassium concentration decreased markedly while the concentrations of the other two electrolytes again moved in the opposite direction. Once the urinary volume improved to a range of 500 to 800 ml. per 24 hours, the concentrations of all three electrolytes remained relatively stable.

While definite conclusions obviously cannot be drawn from such meager data, these findings tend to support the factual observations and the theory advanced by Meroney and Rubini[3] who proposed the concept that not all tubules are damaged in acute tubular necrosis. A certain number of totally or partially functioning tubules still remain, and oliguria is due to mechanical obstruction of damaged tubules by debris and edema. Release of this obstruction is sudden and accordingly, improvement or recovery is heralded by sudden diuresis. However, urine thus released is dilute and the mixture of this urine with that from the normally functioning tubules results in the output of urine of lowered potassium concentration. The period of marked oliguria, then, appears to reflect the maximal functional capacity of whatever undamaged tubules are left, at least with respect to the handling of potassium ions.

Finally, during the last few days of this patient's life, a gradually diminishing output of urine was noted, with a concomitant gradual decrease in the urinary concentration of sodium and chloride ions. However, potassium concentration was not altered appreciably until suddenly, two days before the patient died, a marked drop in urinary potassium concentration occurred without any appreciable change in urine volume. The significance of this phenomenon, if any, is not explained but if such an observation can be made in other similar cases, this phenomenon perhaps may be utilized as an ominous sign indicating complete irreversibility of renal damage.

Charts and photographs prepared by Mr. Anthony M. Kuzma.

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Post Doctoral Scholarships

The Sister Elizabeth Kenny Foundation announces continuation of its program of post doctoral scholarships to promote work in the field of neuromuscular diseases. These scholarships are designed for scientists at or near the end of their fellowship training in either basic or clinical fields concerned with the broad problem of the neuromuscular diseases.

The Kenny Foundation Scholars will be appointed annually. Each grant will provide a stipend for a five-year period at the rate of $5,000 to $7,000 a year depending upon the scholar's qualifications. Candidates from medical schools in the United States and Canada are eligible.

Inquiries regarding details of the program should be addressed to: Dr. E. J. Huenekens, Medical Director, Sister Elizabeth Kenny Foundation, Inc., 2400 Foshay Tower, Minneapolis 2, Minn.

Urology Award

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Palmer House, Chicago, Illinois, May 16–19, 1960.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1959.

SPECIAL TO THE JOURNAL

Report of the "Bicillin" Program in Wisconsin

Recognizing the importance of continuous prophylactic medication for children with rheumatic fever and the fact that many families are unable to assume the cost for such long-term medication, the Bureau for Handicapped Children, under the direction of its State Medical Advisory Committee and in cooperation with the Wisconsin Heart Association, University Hospitals, and Wyeth Laboratories, set up a statewide program to supply benzathine penicillin G (Bicillin) at a reduced rate. Since the statewide program has now been in effect for two years, it was felt advisable to report the results to date and to give a brief outline on how the program works.

History: In October 1954, oral Bicillin (200,000 unit tablets) was made available to the Bureau for Handicapped Children by the Wyeth company at 5¢ per tablet. It was to be dispensed by the University Hospitals and was available to patients in the Convalescent Home for Rheumatic Fever; those active in the University Hospital Rheumatic Fever Clinic which serves the state; and those seen in the Visiting Nurse Service Rheumatic Fever Clinic in Madison. In March 1957 service was extended to include congenital heart patients and those whose diagnosis is confirmed by the Wisconsin Heart Association Mobile Clinics which are held throughout the state.

Objective: To make oral penicillin prophylaxis available for children with rheumatic fever, rheumatic heart disease, and congenital heart disease when it is economically impossible for the family to supply continuous prophylaxis at the retail price.

Eligibility: The diagnosis of rheumatic fever or congenital heart disease must first be confirmed at one of the above clinics. The patient must be under 21 years of age. The family physician must request this service from the Bureau for Handicapped Children for his patients.

Registration: TEMPORARY: A six months' supply of Bicillin is available to the family physician for his patients with rheumatic fever or congenital heart cases on a temporary basis. This must be requested by the family physician. The Bicillin is then sent with the understanding that the child will have an evaluation at a special clinic before he can be registered in the permanent program.

PERMANENT: Registration in the permanent program is made at the request of the family physician after he has received the report of evaluation at one of the special clinics. These clinics include the University Hospital Rheumatic Fever and the Congenital Heart Clinics, which serve the state; the Visiting Nurse Service Rheumatic Fever Clinic in Madison; and the Wisconsin Heart Association Mobile Clinics.

Financial Eligibility: The family physician certifies that he is the physician in attendance and that the family cannot pay the retail price for the drug. He may recommend the reduced rate (5¢ a tablet) or that the Bureau for Handicapped Children supply the drug at no cost to the family.

Refills: The family receives a form for re-ordering which they must present to the family physician for his signature if he wishes to have the prophylaxis continued.

Report on Program to Date

Patients on Temporary Program	45
Patients on Permanent Program (includes hospital and Wisconsin Heart Association Clinics)	500+

REPORT ON 1958 WISCONSIN HEART ASSOCIATION CLINICS

Recommended for prophylaxis	153
Registered for prophylaxis	122
Family paying costs	96
Bureau paying costs	24
Welfare paying costs	2

STATUS OF 1957 CASES AT THE END OF TWO YEARS

Recommended for prophylaxis	218
Registered for prophylaxis	152
Family paying costs	116
Bureau paying costs	31
Welfare paying costs	5
Now on active roles	116
Moved out of state	8
Closed as delinquent permanently	3
Reported to local physician as delinquent in March 1959	14

Information: Information may be obtained about the Wisconsin Heart Association Mobile Clinics by writing to Miss Elizabeth Moxley, Director, 205 West Highland Avenue, Milwaukee 1, Wisconsin.

Other information may be obtained by writing to the Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, Wisconsin.

How the Public Health Nurse Can Assist the Physician with His Cardiac Patients

By BERNICE BRYNELSON, R. N.*

Modison, Wisconsin

REHABILITATION, especially as applied to persons with cardiovascular disease, is a positive action, the aim of which is to get the patient (and his relatives) in a healthy, optimistic state of mind, and his body in as good functioning capacity as is possible, so that he may return to society as a producing, independent, creative member. This definition was arrived at by a group of general medical practitioners surveyed in 1957—a committee of several eminent cardiologists among whom were such outstanding physicians as Paul D. White and Howard A. Rush.

The public health nurse may be of assistance to the physician in helping the patient and his family achieve these objectives. The nurse can visit the patient in his home and observe how the patient is getting along on the regimen recommended by the family physician, and keep the physician informed. This is especially important where visits to the physician are infrequent.

If the patient is a child and has rheumatic heart disease or a congenital heart malformation, the nurse can help the parents and the child to live as normal a life as possible within the limits of his capacity. It is known that children who have corrected malformations of the heart, and could return to normal childhood activities, are often not only overprotected by their parents but also by teachers and neighbors. The public health nurse can help interpret to these individuals what activities the child should be permitted to do and, in this important respect, be a liaison between the doctor, the family, and the school teachers. The nurse can also help the doctor keep the rheumatic heart disease patient under continuous medical care and interpret to the family the need for and value of continuous prophylaxis.

The public health nurse can also be of great assistance to the family physician when his patient has congestive heart failure. She can assist the patient and his family with the use and preparation of low sodium diets when prescribed. She can also help interpret to the patient why he must take some medications continually, such as digitalis, and save much of the doctor's time. When there is a Visiting Nurse Association in the community, they will give hypodermic diuretics if requested by the physician.

Patients who have strokes can be assisted in their homes by public health nurses. With the doctor's approval, they can teach families how to put the affected limbs through normal range of motion and teach the family bed positioning. They can also help in rehabilitation by encouraging the patient to do as much as he can with his unaffected side. The booklet, "Strike Back at Stroke," which graphically illustrates exercises for the hemiplegic, is available to doctors to help them prescribe the exercises they want the patient to do. The nurse, in turn, can teach these to the patient and his family.

The patient with hypertensive heart disease is often on drugs as well as various types and combinations of diet such as reducing diets or restricted sodium. Besides helping the patient with his diet, the public health nurse may be able to help him with his accompanying emotional problems which may contribute to his elevated blood pressure.

Many of these patients are in the older age group and some of them live alone. Under such circumstances, they do not always seek medical advice when they should. The public health nurse can help keep them under regular medical care.

The public health nurse knows the community resources and can help the physician secure these for his patient.

The occupational health nurse, in industrial plants, can also be of assistance to the family doctor when his patient goes back to work. She can observe, for the physician,

* Consultant Nurse in the Division of Chronic Disease and Aging, Wisconsin State Board of Health.

how the patient is able to function on the job and can also help by interpreting to management any special considerations the physician may feel the patient may need.

With the physician as the team leader and everyone working together, the patient will benefit the most. It must be appreciated that much as the public health nurse can do, she can be of no service to either the patient or the physician unless the doctor requests her assistance in these time-consuming and valuable phases of medical care.

POTENTIAL SIDE-REACTIONS OF TRANQUILIZING AGENTS . . .

(continued from page 356)

fluids. Any central nervous system stimulating medication should be avoided.

Another, less frequent side-effect is hypotension which may advance rapidly to the picture of shock. Intravenous fluid therapy with L-arternol (Levophed) offers the best symptomatic treatment.

Not all compounds of the group of phenothiazines share the same degree and frequency of the mentioned untoward reactions. But reports of complications which continue to follow after a variable interval the introduction of newer, supposedly safer derivates should cause the practicing physician to think of these possibilities whenever pathologic findings which fall into the outlined symptoms are encountered in a patient who is taking phenothiazine products. Also a close observation for side-effects is important in patients who accidentally ingested phenothiazines. This concerns especially preschool children who traditionally contribute the majority of cases with accidental ingestion of drugs as well as of commercial household products.[3]

Also meprobamate has resulted in side-effects which are in part similar to those described for phenothiazines.[4] Allergic dermatitis can appear following very small dosages of this medication in patients who have no previous history of an allergy to other substances. Chills and fever may accompany the skin manifestations or may be the only symptom. It usually occurs rapidly, sometimes following the first dose, which is in opposition to this complication caused by the phenothiazines.

Another reaction is seen in an increased capillary permeability resulting in petechial hemorrhages in the presence of normal platelet counts. More severe reactions involve vasodilation, hypotension, or even coma and arreflexia.

The treatment for each of these side-effects includes the complete and immediate withdrawal of the tranquilizing medication supported by symptomatic treatment, which is usually only required for patients with coma or hypotensive shock.

Reserpine has not come to the attention of our Information Center as causing any diagnostic difficulties either by cases with side-reactions or by accidental ingestion. Its application for the treatment of hypertension surmounts that as a tranquilizing agent. The infrequent use of reserpine in children may additionally explain the apparent absence of difficulties as we experience them for the two mentioned groups.

The Poison Information Center at the University Hospitals, Madison, Wisconsin, which was established with the assistance of the Dane County Medical Society and the Madison City Health Department, can be reached by phone night and day . . . Alpine 6–6811.

We are indebted to the practicing physicians in Wisconsin, who generously offered follow-up information on their patients.

Side-effects include nasal congestion, drowsiness, and—in higher dosages—Parkinsonism and seizures.

Summary

While the value of tranquilizing agents has been demonstrated in the treatment of many psychiatric and physical diseases and symptoms, it has not been followed by the general awareness of its potential side-effects which are associated with therapy that approaches the suggested maximal dose or with an obvious overdosage. Particularly, the stimulating effect by the phenothiazines of the central nervous system and the hypotensive properties of meprobamate continue to offer differential diagnostic problems.

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Editors
HARRY BECKMAN, M. D., Marquette University
F. E. SHIDEMAN, M. D., University of Wisconsin

COMMENTS ON TREATMENT

Advances in the Medical Treatment of Epilepsy

By FRANCIS M. FORSTER, M. D.*
Madison, Wisconsin

MODERN TREATMENT in the epileptic patient has progressed so well that it is now possible to control the seizures in at least 85% of the patients. The armamentarium of the physician has been greatly amplified and, indeed, the field is not unlike that of the antibiotic field. Here too there is a complexity of drugs with varying spectra and with complications and contraindications. The increasing diagnostic skills in epilepsy, both clinical and laboratory, have made it possible to differentiate the types of seizures more adequately, and have made the prescribing of drug therapy more meaningful, since certain kinds of drugs are indicated for certain kinds of seizures. Only two decades ago psychomotor seizures were scarcely differentiated clinically from petit mal seizures. The awareness that purposeful irrelevant activity occurs in psychomotor seizures gave a clear differentiation. This was extremely important because of the development of the oxazolidines. Patients being treated with trimethadione (Tridione) or paramethadione (Paradione) for psychomotor seizures are not only not improved but even can become worse. Hence the differentiation between petit mal and psychomotor epilepsy is highly important. Fortunately both diagnostic and therapeutic achievements are parallel so that the differential diagnosis is not an academic one but leads to seizure control.

The most important drug to be introduced in recent years is a pyrimidine called primidone (Mysoline). This is the drug of choice in the treatment of psychomotor epilepsy and in focal seizures, and is of particular value in the handling of intractable cases of grand mal epilepsy. Fortunately, there are no major complications of Mysoline therapy. There are no blood dyscrasias or hepatitises attributable to this drug. There are, however, some rather important complications early in the use of Mysoline. About 1 out of 40 patients taking this drug develop, on a single dose, a severe bout of vomiting and wretching, which can be partially alleviated by the use of promazine. The other complication is severe drowsiness which may last for a week. Medication should be continued in spite of this severe drowsiness and sleepiness for after about a week the patient becomes accustomed to the medication. It can then be continued without any further sleep disturbance.

Another new medication for the treatment of major and psychomotor seizures is Peganone. This too is a hydantoinate and, therefore, is somewhat closely related to diphenylhydantoin (Dilantin) and Mesantoin. It is not as effective as Dilantin, nor as toxic as Mesantoin. Peganone is a safe drug and can be used to supplement hydantoinate therapy for grand mal or psychomotor epilepsy.

Petit mal epilepsy still remains an area of particular challenge. While there is a reasonable number of drugs available for treatment in this area, they are not yet entirely satisfactory. The oxazolidines, Tridione and Paradione, remain the standbys. Since Tridione and Paradione can precipitate major seizures in the patient, it is important always to add phenobarbital to the Tridione and/or Paradione therapy. This serves to protect against major seizures. Phensuximide (Milontin) is less successful than the oxazolidines, but virtually nontoxic. Celontin like Milontin is a succinimide and like Milontin is a safe drug but neither is of the same degree of efficacy as Tridione or Paradione. However, some patients will respond only to the succinimides.

It is important that the search for new medications continue and that epilepsy clinics, such as the one at the University Hospital, must constantly be working with new

* Chairman, Department of Neurology, University of Wisconsin Medical School, Madison.

medications in the search for more perfect control of seizures. One of the drugs which is at the present time nearing the close of its clinical trials shows considerable promise. This drug is Elipten, and should be available within a few months. Elipten is similar to glutethimide (Doriden) in chemical structure and has a definite role in improving the therapy, particularly of petit mal epilepsy. Like Doriden it has a frequent complication of skin rash early in the course of therapy, but this is not a serious complication and does not rule out Elipten therapy. In our own experiences here in the Epilepsy Clinic we have found this a valuable adjuvant drug, that is one which oftentimes will turn the tide when added to partially successful medication.

ORTHOPEDIC FIELD CLINICS

July 1, 1959–December 31, 1959

STATE DEPARTMENT OF PUBLIC INSTRUCTION, BUREAU FOR HANDICAPPED CHILDREN

CRIPPLED CHILDREN DIVISION, MADISON 3, WISCONSIN

LOCATION	*DATE*	*EXAMINER*
Ashland	July 8 and 9	C. M. Ihle, M. D.
Darlington	July 15	R. C. Wixson, M. D.
Wausau	August 20	W. I. Norton, M. D.
Manitowoc	September 2 and 3	F. G. Gaenslen, M. D.
Marinette	September 9	J. W. Nellen, M. D.
Kenosha	September 23	C. A. Sattler, M. D.
	September 24	L. T. Schlenker, M. D.
Racine	September 30	C. W. Christenson, M. D.
	October 1	M. W. Nelson, M. D.
La Crosse	October 6 and 7	J. E. Miller, M. D.
Superior	October 9	D. W. McCormick, M. D.
Chippewa Falls	October 14 and 15	H. I. Okagaki, M. D.
Sheboygan	October 28 and 29	H. W. Wirka, M. D.
Rhinelander	November 3 and 4	H. I. Okagaki, M. D.
Eau Claire	November 12 and 13	R. P. Montgomery, M. D.
Appleton	November 19 and 20	H. W. Wirka, M. D.

FOR: The clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinics so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, Wisconsin.

Editorial Director
DAVID N. GOLDSTEIN, M. D.

EDITORIALS

Answer to Many Needs

We have in our State one of the most worthy objects of financial support yet devised by physicians. That the total of contributions to this organization has been less than praiseworthy can only mean that its existence has not been adequately publicized.

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin has been operative since 1955. In its brief span the good work it has done could fill volumes. Every physician in the State can be proud that he supports an easily accessible source of loans to needy medical students, emergency assistance to distressed colleagues or their widows, and enshrinement of medical history in the state.

The "voluntary contribution" of $10.00 per year assessed by the House of Delegates has fallen shamefully short of the goal. One county medical society, the tri-county group of Columbia, Marquette, and Adams, recently contributed $500.00 to the student loan fund—an amount almost equal to the sum raised through the mechanism of "voluntary contributions." A little mental arithmetic discloses a truly appalling minute percentage of the membership really concerned with this annual request by the House of Delegates.

The practicing physician is beseeched almost constantly for donations to various "do good" organizations, building campaigns, and special health groups. Many doctors, by nature generous, have a desire to contribute to worthy causes but have no opportunity to study the various organizations involved, or to plan a program of contributions with any logical design. Funds contributed to the Foundation are certain to be used wisely, in such manner as to benefit and reflect credit on the House of Medicine. A factor of no little importance in the use of these hard earned "professional" dollars is that virtually none of them are sliced off for administrative expense—an item worthy of a lot of reflection.

Many times, too, the cliche about charity beginning at home is heard, with expressions of concern that nothing exists for distressed physicians. Few doctors seem to realize that the Foundation also serves this purpose. Something more appropriate to honor the memory of a deceased friend than sending flowers would be a contribution to the Foundation, for which a memorial card has been developed to be sent to the relatives or friends of deceased persons.

The Charitable, Educational and Scientific Foundation is a tremendously flexible organization with representatives on the board from every county medical society. Gifts are gratefully accepted in any amount, and if desired by the donor may be earmarked for special purposes such as student loan fund, medical museum, microscope loan program, or just plain charity. The money may also be designated for postgraduate educational projects. Already in operation are an inhalation therapy institute, athletic injuries institute, and hearing loss studies. Special projects supported by earmarked funds, administered by the Foundation, include health insurance for the aged and cost of medical care in the hospital.

There is a list without limit of special studies, educational projects, and other areas of financial support that could be undertaken by the Foundation. All of its work enhances the stature of the medical profession and ultimately benefits the public as a whole.

Those who know the Charitable, Educational and Scientific Foundation have boundless enthusiasm for its work. Those who learn about the Foundation will share the conviction that no more worthy beneficiary of the physicians' contribution dollar could be conceived.

It is hoped that county medical societies all over the state will follow the example set by Columbia, Marquette and Adams for disposition of surplus funds. And individual gifts are guaranteed to make the donor feel good.

Of Interest to Every Physician

The accomplishments, aims and goals set forth by the State Medical Society during the past year are summarized in the House of Delegates reports which appear in this issue of the *Wisconsin Medical Journal*.

These reports give a comprehensive review of the numerous fields in which not only the physician but also the public have a deep concern. Every member of the Society should be aware of the activities of his House of Delegates for it is this body that directs the role of medicine in Wisconsin.

In this time of major medical decisions, we urge every member to carefully read these reports.

(Continued on page 379)

The President's Page . . .

A TRIBUTE TO THE RED CROSS NURSE

This summer marks the golden anniversary of the American Red Cross nursing services. As a full member of the health team, the Red Cross nurse stands forth as unique. She has become, through the long decades of history, a respected, heroic, almost legendary figure.

The Red Cross nurse is the servant and symbol of something rare in the world—a voluntary agency. Mark that word "voluntary"—a voluntary agency which is ever on the scene when there is need, when there is disaster, when there is war. The Red Cross nurse has become a universal emblem of relief in time of trouble.

It was on May 9, 1909, that the Red Cross nursing service was launched nationally. From then on it has been on call constantly: the Ohio River flood of 1913, World War I, the flu epidemic of 1918, to name a few. Still cruelly close to all of us are the effects of World War II. And for that all-consuming holocaust, the Red Cross provided a total of 78,000 nurses who served with our Armed Forces in every theatre of operations. They were on duty during the Korean conflict as well.

But there has been another role—not a very glamorous one—the quiet, undramatic, yet splendid performance of the home nursing service. First initiated in 1910, that program of the Red Cross—though unspectacular to the public eye—has rendered distinguished service to American public health for half a century. In the United States last year some 218,000 women, high school girls, men and boys were taught Red Cross home nursing. Nor was home nursing ever more in demand nor with a more promising future.

As I stated above, the Red Cross nurse represents something rare in the world: a voluntary agency ever on the scene when human misery erupts. Noah Webster, that impartial educator, defines the word "voluntary" as meaning "ready, spontaneous, willing, of one's free will, from one's own choice, unconstrained by interference." Surely the Red Cross means all of these things, for the Red Cross in America is an expression of the people of this country, demonstrating that they are ready, and willing to help anyone in a time of trouble. They give spontaneously, they choose to give, and they give without governmental interference.

The operative word is "giving . . ." a gift, not through taxation. And there is a considerable difference. All of us are taxed, even in death. But in the American Red Cross we have an agency to which we can give freely, as it pleases us, unconstrained by interference.

There is something else. We give because we have confidence in the Red Cross. Let me cite one clear example: this agency's task in furnishing vital blood supplies to the ill and injured. Certainly it speaks of confidence when, in area after area across the United States, the Red Cross has become the sole agency to gather blood not only for emergencies but for daily medical care. I cannot think of another volunteer group which performs such a critical mission. It is a rare trust.

I judge the American Red Cross to be an excellent example of American free enterprise at work, free enterprise with that touch of humanity which is so uniquely characteristic of this country.

We physicians have fought, are fighting, and will continue to fight the many attempts by government to control medicine, attempts by nonmedical groups to dictate medical judgment. And in this continuing struggle we need allies from the other specialists in the health field, like the American Red Cross. *(Continued on page 379)*

If free enterprise has made this the greatest nation on earth, the same free enterprise in medicine, the freedom of the physician to practice according to high standards, the freedom of the patient to choose that physician, has also brought about a nation whose health is supreme by any standards.

The threat to control medicine as practiced by physicians today has far reaching impact. That threat moves to blanket all who are allied with the physician in the fight against disease. It specifically includes the American Red Cross.

As I told Red Cross officials earlier this month, there should be no doubt in their minds about their future if creeping control of medicine by legislation continues to advance. No bureaucratic machine in the world needs, depends upon or wants the service of a voluntary agency when it can be obtained by edict. The volunteer becomes the draftee, compulsion is the password.

In paying tribute to the Red Cross nurse I must also issue a stern warning. She must resist all attempts to control her distinguished humanitarian service. She must remain the servant and symbol of all that's best in America: the volunteer, bold, energetic, free; the universal emblem of relief in a time of trouble.

The Red Cross nurse, as I have said, is a respected, heroic, almost legendary figure. Let us be determined that she does not vanish into legend altogether.

William B. Weldon, M.D.

EDITORIALS (continued)

Project HOPE

A unique concept in the field of international health has been inaugurated recently by the People-to-People Health Foundation, the corporate entity of the Committee on Medicine and Health Professions of the People-to-People Program.

The Foundation is in the process of raising $3,500,000 to staff and outfit the mothballed Navy hospital ship CONSOLATION as a floating medical center to be sent on a year's visit to Southeast Asia.

The project's efforts will be primarily directed toward bringing the latest techniques and skills developed by the American medical professions to the medical and paramedical personnel in the Far East in their own environment, adapted specifically to their own needs and their way of life.

Intended as a concrete expression of the concern felt by the people of the United States for the people of other nations, the project will be neither a "do-good" nor a one-sided program. Dr. William B. Walsh, the project's head, expects the knowledge and experience gained by the American medical staff to be immensely valuable.

The ship will be staffed with both permanent and rotating medical personnel. Some 15 physicians, expert in various fields of medicine and surgery, two dentists, 20 graduate nurses and 20 technicians will spend a full year with the ship. The remainder of the medical personnel will consist of volunteer units of generalists and specialists who will be flown to the ship for tours of four months. While some of the rotating personnel will remain with the ship, many will use the vessel as a logistic base to support their work inland with mobile units.

The project's success will depend solely on the support of individuals, corporations, foundations and, perhaps most important, the American medical profession. The American Medical Association and the American Dental Association have publicly endorsed the plan and have pledged generous financial support.

Although a lack of time precludes an extensive appeal to the public at present, widespread individual support is necessary. Donations—which, of course, are tax deductible—may be sent to Project HOPE, P. O. Box 9808, Washington, D. C.

Early Midwest Drug Store

The rise of the drug trade paralleled the development of medicine in the Midwest during the early 1800's. For the most part, the United States depended upon Europe for its drugs, and prior to 1830 Midwestern druggists made annual purchasing trips to eastern ports for their wares. But after the 1830's large stores in such cities as Detroit and Chicago, were able to supply the small local druggists.

Not without reason were pestle and mortar (or bottles and balances) the sign of the drug store. Sugar of milk, gum arabic, opium, bloodroot—in fact, most powders except jalap, rhubarb, and ipecac—were produced by slow and monotonous work with pestle and mortar.

An old account records: "Sugar of milk came in what we called 'cobs' because it looked somewhat like an ear of corn. A stick 12 or 14 inches long was put in the saturated solution which crystallized about the stick. This was extremely hard to powder. A man might work it in a mortar all day and not get more than a pound. A day's work might not furnish more than two pounds of powdered gum arabic."

A ponderous iron mortar, a tincture press and a Swift's drug mill were the ever present dread of the apprentice.

In addition to paints, varnishes, glassware, and doctor's instruments (and at times hardware, notions, and even groceries), the drug store handled "patent" medicines, wines, soft drinks, and usually hard liquor as well. Brandy, port and sherry were for "medicinal" purposes.

The drug store's chief competitors in the sale of both patent medicines and liquor were the general store, so well known as a dispenser of whiskey as to be called a "groggery" rather than a grocery by those with a prohibition bias. The old whiskey barrel, beside the cracker barrel, beside the wheel of cheese, beside the hot stove, also provided potent competition for the druggist.

The book store or the stationer's shop, which often had monopoly right on certain of the proprietary medicines, cut the druggist's trade, too.

Truly the early drug store was the department store of its day. As was the general store, it was willing, especially during scarce-money days, to accept beeswax, ginseng, flaxseed and hempseed, and other articles in trade. But after 1840 the Midwest drug store began to restrict its functions more specifically to drugs, only to become a general store again in the twentieth century.

Druggists, like many doctors, learned their trade by the apprentice system, and trained chemists were few.

Dr. Fred J. Pfeifer of New London is shown above cranking up his "snowmobile" in 1924. Doctor Pfeifer was honored this year by his community and the State Medical Society for practicing medicine 50 years. A story about "Doctor Pfeifer Day" appears elsewhere in this issue.

Before the days of his "snowmobile", Doctor Pfeifer's friends recall an incident which indicated the importance of the methods of travel for the doctor in those early days.

When Doctor Pfeifer located in New London in 1909, the auto was quite new. One of the three or four who had an automobile was George Spurr, grandfather of the present George Spurr. Doctor Pfeifer was called out to the Spurr farm and it was necessary for Spurr to come to town to get medicine. The Doctor had an Arabian, fast-traveling horse and Spurr had trouble trying to keep up with him; and when they got to town, Spurr told the Doctor that he did not have any use for an auto as long as he had that horse.

Announcing

SPEAKERS' SERVICE

TO

COUNTY MEDICAL SOCIETIES

AND

COUNCILOR DISTRICT MEETINGS

A Service of

State Medical Society Charitable, Educational and Scientific Foundation

In Cooperation With

COUNCIL ON SCIENTIFIC WORK
WISCONSIN STATE BOARD OF HEALTH
MARQUETTE UNIVERSITY SCHOOL OF MEDICINE
UNIVERSITY OF WISCONSIN MEDICAL SCHOOL
WISCONSIN HEART ASSOCIATION
AMERICAN CANCER SOCIETY, WISCONSIN DIVISION
WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION
WISCONSIN COUNCIL FOR MENTALLY RETARDED CHILDREN

M. F. HUTH, M. D.

Of Help to You!

On the following pages are listed the names of faculty members at our two medical schools, and others recommended by cooperating agencies, who have indicated their willingness to speak to county medical societies as part of a new service to members, developed through the Council on Scientific Work, and being financed by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

The primary purpose of this Speakers' Service is to encourage more county medical societies, particularly the smaller groups of physicians, to schedule more meetings of a scientific, educational nature. While the importance of medical economic matters cannot be minimized, the basic purpose and function of medical practice is treating patients. This suggests the need for continuous study and securing information on new findings of medical research. To assist in this objective the Council on Scientific Work is pleased to present this program.

To make this service of maximum effectiveness we must have scheduling of speakers far in advance. We urge that you and your associates carefully review the listing of speakers and subjects, and consult with your county medical society officers and program chairman, to develop a year's program of speakers. The State Medical Society office will arrange for speakers, and reimburse speakers for services rendered. *All we ask of you is that you provide an interested and attentive audience.*

CONTACT YOUR COUNTY SOCIETY OFFICERS SOON, SO THIS PROGRAM CAN START IN SEPTEMBER 1959.

Sincerely yours,

M. F. Huth M.D.

MELVIN F. HUTH, M. D.
Chairman, Council on Scientific Work

MARQUETTE UNIVERSITY FACULTY

Dermatology

D. E. HACKBARTH, Asst. Clin. Prof.

(1) An Appraisal of Current Dermatological Therapy
(2) Common Dermatological Problems

D. W. KERSTING, Prof. and Chr., Dept.

(1) Diagnosis and Treatment of Benign Dermal Neoplasms
(2) Bullous Skin Disease
(3) Bullous Skin Disease in Children
(4) Bullous Skin Disease in the Adult
(5) Dermatological Education and Experience—Undergraduate and Postgraduate

L. S. MARKSON, Asst. Prof.

(1) Leg Ulcers—Types and Treatment
(2) Stasic Eczema and Ulcers Management, Lower Extremities
(3) Modern Therapy in Dermatology

M. J. REUTER, Asst. Prof.

(1) Eczematous Eruptions of the Hands (Hand Eczema)
(2) Pigmented Lesions of the Skin
(3) Industrial Dermatitis

DONALD M. RUCH, Asst. Clin. Prof.

(1) Proper Diagnosis and Treatment of Common Skin Diseases
(2) Drug Eruptions
(3) Cutaneous Manifestations of Internal Disease
(4) Do Not Be Rash With the Rash Problem

Medicine

J. A. ARKINS, Clin. Instr., Allergy Clinic and Pulmonary Function Lab., Milwaukee County Hosp.

(1) Allergic Disease
(2) Drug Allergy
(3) Pulmonary Function

W. V. BAKER, Clin. Instr.

(1) Cardiology: The Cardiac Patient and His Ability to Work
(2) Thyroid Disorders

REUBEN BEEZY, Asst. Prof.

(1) Antibiotics and Infectious Disease
(2) Hepatic Manifestations of Sarcoidosis
(3) Staphylococcal Disease Today

J. O. CHAMBERLAIN, Clin. Instr.

(1) Diseases of the Thyroid Gland with Particular Emphasis on Diagnosis and Therapy

HOWARD L. CORRELL, Assoc. Clin. Prof.

(1) Related to Diseases of the Heart

B. H. DESSEL, Asst. Prof.

(1) Hodgkin's Disease

N. H. ENGBRING, Instructor

(1) Hyperthroidism
(2) Hypothyroidism (and Hypometabolism)
(3) Diabetes Mellitus

MARK W. GARRY, Assoc. Prof.

(1) Rheumatic Diseases

NATHAN GROSSMAN, Asst. Clin. Prof.

(1) Pulmonary Heart Disease (acute and chronic cor pulmonare)
(2) Congenital Heart Disease
(3) Cardiac Fluoroscopy in Rheumatic and Congenital Heart Disease

JOHN H. HUSTON, Asst. Prof., Acting Dir., Section of Cardiovascular Disease

(1) Selection of Patients for Cardiac Surgery
(2) Physiologic Approach to the Cardiac Patient Most anything in Cardiology that is wanted

(The above topics relating to cardiovascular hydrodynamics are presented as a talk and demonstration with use of a special mechanical exhibit and models.)

R. P. JAHN, Asst. Clin. Prof.

(1) Pulmonary Tuberculosis (any aspect)
(2) Pulmonary Emphysema
(3) Pulmonary Functions

H. J. KANIN, Clin. Instr.

(1) The Physical Effects of Nervous Tension
(2) The Irritable Colon
(3) The Management of Massive Gastrointestinal Hemorrhage

ROSS C. KORY, Assoc. Prof.

(1) Pulmonary Function Impairment
(2) Pulmonary Emphysema
(3) Inhalation Therapy
(4) Heart Catheterization
(5) Recent Advances in the Diagnosis and Treatment of Heart Disease

HOWARD LEE, Asst. Clin. Prof.

(1) Bronchial asthma
(2) The Neglected Disease—Atropic Rhinitis
(3) Obstructive Pulmonary Disease

E. J. LENNON, Instr., Fellow, Dept. Metabolism

(1) Oral Hypoglycemic Agents in the Treatment of Diabetes Mellitus
(2) Fluid and Electrolyte Problems in Diabetic Acidosis
(3) Primary Aldosteronism
(4) Primary Myxedema—An Autoimmune Disease?

M.C.F. LINDERT, Assoc. Clin. Prof. (Internal)

(1) Differential Diagnosis of Acute Hepatic Diseases
(2) Diagnostic Problems in the Jaundiced Patient

MISCHA J. LUSTOK, Asst. Clin. Prof. (Cardiology)

(1) Medical Management of Arterial Hypertension
(2) Management of Acute Cardiac Arrhythmias
(3) What are the Surgical Opportunities for Treatment of Heart Disease?

(4) Myocarditis, Nonspecific Inflammation of the Myocardium
(5) Coronary Heart Disease, Complicated by Congestive Heart Failure or Arterial Hypertension

JULIUS M. MEYER, Asst. Clin. Prof.
(1) Diabetes, Arthritis

TIMOTHY R. MURPHY, Assoc. Clin. Prof.
(1) Congestive Heart Failure
(2) Treatment of Arrhythmias

B. J. PETERS, Assoc. Clin. Prof.
(1) The Kidney in Diabetes
(2) Kidney Disease
(3) Glomerulonephritis
(4) Diabetes Mellitus
(5) Pancreatitis—Acute and Chronic Pancreatitis

ANTHONY PISCIOTTA, Assoc. Prof.
(1) General Aspects of Anemia
(2) Pernicious Anemia
(3) Iron Deficiency Anemia
(4) Hemolytic Anemia
(5) Simple Chronic Anemia
(6) Leukemia, Lymphoma, Hodgkin's Disease
(7) Agranulocytosis and other Hemorrhagic Drug Reactions
(8) Any Hemolytic Subject in which the County Medical Society Expresses Interest

A. J. QUICK, Prof. of Biochemistry & Dir., Dept.
(1) The Common Hemorrhagic Diseases: Their Diagnosis and Management
(2) Thrombosis and Thrombo-Embolism
(3) Hereditary Diseases: Their Increasing Importance in Modern Medicine

J. W. RASTETTER, Assoc. Prof. & Asst. Chr., Dept.
(1) Chronic Alcoholism
(2) Collagen Diseases
(3) Cancer

F. F. ROSENBAUM, Assoc. Clin. Prof.
(1) The Diagnosis and Management of Acute Myocardial Infarction
(2) Diagnosis and Management of Paroxysmal Cardiac Arrhythmias
(3) The Place of the Electrocardiogram in Cardiac Diagnosis

D. A. ROTH, Instr., Chief Metabolic Service, Wood VA Hosp.
(1) Experiences with the Kolff Artificial Kidney
(2) The Treatment of Renal Insufficiency
(3) Potassium Depletion

E. G. SCHULZ, Clin. Instr.
(1) Artificial Kidney
(2) Glomerular Nephritis
(3) Nephrotic Syndrome

L. R. SCHWEIGER, Assoc. Clin. Prof.
(1) Genitourinary Diseases

MICHAEL W. SHUTKIN, Assoc. Prof.
(1) The Modern Therapy of Chronic Ulcerative Colitis
(2) The Modern Therapy of Regional Enteritis
(3) Present Day Management of Peptic Ulcer

W. H. THIEDE, Clin. Instr.
(1) Tests of Pulmonary Functions
(2) Pulmonary Emphysema
(3) Alveolar—Capillary Block Syndromes

BURTON A. WAISBREN, Asst. Clin. Prof.
(1) Infectious Diseases and Chemotherapy
(2) "Low Brow" Electrocardiogram

R. R. WELLER, Clin. Instr.
(1) Bronchial Asthma
(2) Allergic Diseases in Children
(3) Treatment of Allergic Emergencies

Neurology

F. J. MILLEN, Assoc. Prof.
(1) Headaches, Their Differential Diagnosis and Treatment
(2) Epilepsy, or Convulsive Disorders, Their Diagnosis and Treatment
(3) Demyelinating Diseases of the Nervous System

Obstetrics and Gynecology

F. J. HOFMEISTER, Assoc. Clin. Prof.
(1) The Complete Office Gynecological Examination (film and lecture)
(2) The Problem of Ovarian Tumors
(3) Cancer Detection in a Private Practitioner's Office

G. S. KILKENNY, Assoc. Clin. Prof.
(1) All subjects pertaining to obstetrics and gynecology

JACK A. KLIEGER, Assoc. Prof.
(1) Anything pertinent to Obstetrics and/or Gynecology

ALEX KREMBS, Asst. Clin. Prof.
(1) Paranatal Mortality
(2) Vaginal Hysterectomy

F. J. STODDARD, Assoc. Clin. Prof.
(1) Menstrual Abnormalities
(2) Gynecologic Endocrinology
(3) Pediatric Gynecology
(4) Leukorrhea
(5) The Adrenal Gland in Gynecology
(6) Infertility

Occupational and Environmental Medicine

O. A. SANDER, Assoc. Clin. Prof.
(1) Current Concepts of the Pneumoconioses
(2) Present Status of Tuberculosis, Both Occupational and Nonoccupational

Ophthalmology

L. L. GARNER, Clin. Instr.

(1) Glaucoma, or matters related to the prevention of blindness from glaucoma

Otolaryngology

MEYER S. FOX, Asst. Prof.

(1) What the General Physician Should Know About Loss of Hearing
(2) Hearing Problems in Children
(3) Occupational Hearing Loss—Wisconsin's Approach to the Problem

HOWARD HIGH, Asst. Prof.

(1) Hoarseness
(2) Sinusitis
(3) Hearing Problems

G. D. STRAUSS, Clin. Prof. & Dir.

(1) Surgical Reconstruction of Hearing

Pathology

E. A. BIRGE, Asst. Prof.

(1) Cytology; surgical pathology, especially gynecology; possibly clinical pathology, depending on the exact subject desired

PAUL KIMMELSTIEL, Prof.

(1) Any topic on renal diseases including nephrosis, diabetes, pyelonephritis
(2) Vaginal Smears for Carcinoma of the Uterus

Pediatrics

G. A. KERRIGAN, Asst. Prof.

(1) Convulsive Mechanisms in Hypernatremic Infants
(2) Practical Pediatric Fluid Therapy
(3) Diagnosis and Management of Thyroid Disorders in Children
(4) Diagnosis and Management of Growth Retardation in Children
(5) Management of Adrenocortical Disorders in Children
(6) The Care of Children with Nephrosis
(7) Milk Allergy in Children

SAMUEL E. KOHN, Asst. Clin. Prof.

(1) Diagnostic Criteria for Gastrointestinal Surgery in Infants and Children

S. F. MORGAN, Assoc. Prof.

(1) Rheumatic Fever in Childhood: Its Diagnosis, Prevention and Treatment
(2) Congenital Malformations of the Heart (slides)

K. J. WINTERS, Clin. Instr.

(1) Pediatric subjects of interest to local society
(2) Recent Advances in Pediatrics
(3) "Common Sense" in Rearing Children—Doctors and Parents
(4) Rheumatic Fever, Polio, Contagious Diseases
(5) Premature Infant and Newborn Nurseries

Radiology

J. L. ARMBRUSTER, Assoc. Clin. Prof.

(1) Roentgen Examination of the Chest
(2) Roentgen Examination of the Gastrointestinal Tract and Cholangiography
(3) Pediatric Radiology (preparation of slides for various systems now being done)

IRVING I. COWAN, Assoc. Clin. Prof.

(1) Diagnostic and Therapeutic Uses of Radioactive Iodine
(2) Use of Radioactive Gold in Treatment of Cancer of the Ovary
(3) Treatment of Hyperthyroidism with Radioactive Iodine

S. A. MORTON, Prof.

(1) How X-ray Methods Can Help in the Diagnosis of Heart Disease
(2) The Roentgenographic Aspects of Back Ache
(3) Roentgenographic Aids in the Diagnosis of the Commoner Diseases of the Chest

Surgery

R. H. CASSIDY, Asst. Clin. Prof. (Orthopaedics)

(1) The Treatment of Scoliosis Today
(2) The Significance of Unequal Leg Length
(3) Fractures in Children are Different

DAVID CLEVELAND, Prof. & Head, Dept. Neurosurgery

(1) The Injured Cervical Spine—So-Called Whiplash or Cervical Disc Injury
(2) Early and Late Treatment of Brain Injuries
(3) Surgical Treatment of Parkinson's Disease
(4) Cranio-cerebral Injuries
(5) Peripheral Nerve Injuries
(6) Neurosurgical Diagnosis and Treatment

A. STEPHEN CLOSE, Instr.

(1) Treatment of Intestinal Polyps
(2) Current Concepts on the Nature and Treatment of Hemorrhagic Shock
(3) Cutaneous Necrosis Due to Norepinephrine Administration: Prevention

G. E. COLLENTINE, JR., Asst. Clin. Prof.

(1) Gastrointestinal Hemorrhage
(2) Venous Thrombosis
(3) Cardiac Arrest
(4) Biliary Tract, Surgical Problems
(5) Burns
(6) Hernia

PAUL J. COLLOPY, Asst. Prof.

(1) Treatment and Diagnosis of Low Back Pain
(2) Treatment of Fractures about the Wrist
(3) Treatment of Fractures about the Ankle

JAMES E. CONLEY, Assoc. Prof.

(1) Peripheral Vascular Diseases
(2) Management of Varicose Veins
(3) Detection and Treatment of Colon Cancer
(4) Music and Medicine

C. R. DIX, Asst. Clin. Prof. (Plastic)

(1) Facts and Fallacies on Plastic Surgery
(2) The Treatment of the Injured Face
(3) Tumors of the Head and Neck
(4) Oral Carcinoma
(5) The Use of Skin Grafts and Skin Flaps
(6) The Surgical Treatment of Skin Cancer and Defect Repair
(7) The Treatment of Chronic Radiodermatitis
(8) The Treatment of Facial Defects, Both Congenital and Acquired.
(9) The Surgical Treatment of the Burned Patient, Both Early and Late
(10) Some Problems in Plastic Surgery

WM. H. FRACKELTON, Clin. Prof. (Plastic)

(1) Plastic Surgery—Cosmetic and Functional
(2) Congenital Deformities and Correction
(3) Facial Injuries
(4) Salvaging the Injured Hand

J. J. GRAMLING, JR., Assoc. Clin. Prof.

(1) Carcinoma of Breast
(2) Carcinoma of Stomach
(3) Carcinoma of Colon

PAUL F. HAUSMANN, Asst. Clin. Prof.

(1) The Surgery of Congenital Cardiac Defects
(2) Acute Thoracic Emergencies
(3) Pediatric Thoracic Surgery

JOHN D. HURLEY, Asst. Prof.

(1) Trauma—Diagnosis and Management
(2) Cancer—Diagnosis, Treatment, Palliative Treatment

DERWARD LEPLEY, JR., Instr.

(1) Cardiac Surgery
(2) Thoracic Surgery Topics

A. G. MARTIN, Asst. Clin. Prof.

(1) Gallbladder and Biliary Tree
(2) Gastric Surgery
(3) Colon and Rectal Surgery
(4) Thyroid Surgery

R. T. McCARTY, Clin. Assoc. Prof.

(1) Diagnosis and Treatment of Polyps and Carcinoma of the Rectum and Colon
(2) Office Proctology
(3) Diagnosis and Treatment of Common Proctologic Problems

PAUL NATVIG, Clin. Instr. (Plastic and Reconstructive)

(1) The Treatment of Facial Fractures
(2) The Treatment of Facial Injuries
(3) Cosmetic Facial Surgery
(4) Skin Grafting and Pedicle Flaps

A. H. PEMBERTON, Instr.

(1) Cardiac Surgery
(2) Thoracic Surgery

JAMES M. SULLIVAN, Assoc. Clin. Prof.

(1) Varicose Ulcer
(2) Appendicitis
(3) Arteriovenous Fistulae

JACK L. TEASLEY, Clin. Instr. (Plastic)

(1) Plastic Surgery—Functional and Cosmetic
(2) Treatment of Facial Injuries
(3) Salvaging the Injured Hand

W. D. THOMAS, Asst. Clin. Prof.

(1) Common Bile Duct
(2) Pancreas and Pancreatitis
(3) Peptic Ulcer or Gastric Cancer

HENRY F. TWELMEYER, Asst. Clin. Prof.

(1) Cardiac Surgery
(2) Vascular Surgery
(3) General Surgery

Particular Interest

R. R. WATSON, Clin. Instr.

(1) Carcinoma of the Lung and/or Esophagus
(2) Vascular Surgery in the Elderly Patient

WILSON WEISEL, Asst. Clin. Prof.

(1) Cancer of Lung
(2) Surgical Treatment of Heart Disease
(3) Esophageal Lesions
(4) Thoracic Disorders of the Newborn

SIDNEY K. WYNN, Asst. Clin. Prof. (Plastic)

(1) Primary and Secondary Plastic Repair of Injury
(2) Harelip and Cleft Palate
(3) Early Skin Grafting of Burns
(4) Provision of Proper Skin Coverage

UNIVERSITY OF WISCONSIN FACULTY

Anesthesiology

BETTY J. BAMFORTH, Assoc. Prof.

(1) Infant Resuscitation
(2) Anesthesia Results at University Hospitals
(3) Pediatric Anesthesia
(4) Hypothermia
(5) Common Emergencies in Anesthesia

O. S. ORTH, Prof. and Chr. Dept.

(1) Anesthesia for the Part Time Anesthetist
(2) Current Advances in Anesthetic Agents and Techniques

K. L. SIEBECKER, Assoc. Prof.

(1) Anesthesia for Intracardiac Operations
(2) Anesthesia for Bronchiectasis and Pulmonary Complications
(3) Resuscitation: Respiratory and Circulatory
(4) Anesthesia in Cardiac Surgery

Medicine

E. C. ALBRIGHT, Assoc. Prof.

(1) Current Treatment of Hyperthyroidism with Special Reference to I^{131}
(2) Diagnosis and Treatment of Adult Hypothyroidism
(3) Problems in Thyroid Disease
(4) I^{131} in Treatment of Angina Pectoris

E. L. CHAMBERS, Jr., Asst. Prof.

(1) Diagnosis of Hyperparathyroidism

G. A. COOPER, Asst. Clin. Prof.

(1) Common Dermatitis
(2) Vesicular Eruptions of the Hands
(3) Present Day Problem of Syphilis and Its Treatment
(4) Treatment of Premalignant Lesions and Cancer of the Skin
(5) Naevi: Pigmented and Nonpigmented, Malignant and Nonmalignant

S. B. CREPEA, Assoc. Prof.

(1) Asthma and Its Management
(2) Office Allergy: Diagnostic Methods
(3) Drug Allergy
(4) Pediatric Allergy
(5) Pollinotic Allergy
(6) Rural Allergy

C. W. CRUMPTON, Assoc. Prof.

(1) Coronary Artery Disease
(2) Hypertension
(3) Cardiovascular Physiology in Congenital and Acquired Heart Disease

J. K. CURTIS, Clin. Prof.

(1) Pulmonary Physiology

HELEN A. DICKIE, Prof.

(1) Pulmonary Emphysema and Chronic Bronchitis
(2) Bronchiectasis
(3) Boeck's Sarcoid
(4) Farmer's Lung
(5) Differential Diagnosis of Diffuse Pulmonary Disease
(6) Histoplasmosis and Fungus Disease
(7) Skin Tests and Complement Fixation Tests—Their Place in Differential Diagnosis of Fungus Disease and Tuberculosis

EDGAR S. GORDON, Prof.

(1) Diabetes
(2) Arteriosclerosis
(3) Metabolic Diseases
(4) Endocrinology
(5) Nutrition

D. T. GRAHAM, Assoc. Prof.

(1) Psychosomatic Medicine
(2) Physiology of Emotions

J. R. JOHNSON, Ass't. Clin. Prof.

(1) Sarcoidosis: Problems in Diagnosis and Management
(2) What is Emphysema: Discussion of Types and Management
(3) Identification and Significance of Segmental Disease of the Lung
(4) Current Treatment of Pulmonary Tuberculosis

STURE A. M. JOHNSON, Prof.

(1) Common Skin Eruptions: Their Diagnosis and Treatment

J. D. KABLER, Asst. Prof.

(1) Hyperventilation Syndrome
(2) Treatment of Migraine
(3) Malabsorption Syndromes: Sprue and Similar States
(4) The Placebo Effect
(5) Management of the Delirious Patient

F. C. LARSON, Assoc. Prof.

(1) Atomic Medicine
(2) Advances in Endocrinology
(3) Anti-tuberculosis Medication

O. O. MEYER, Prof. and Chr., Dept.

(1) Treatment of the Anemias
(2) Anticoagulant Therapy
(3) Diseases of Lymph Nodes and Their Treatment
(4) Present Status of the Leukemias
(5) Recent Advances in Therapy
(6) Arthritis

J. F. MORRISSEY, Clin. Instr.

(1) The Value of Serum Transaminase and Other Serum Enzyme Determinations in the Diagnosis of Heart and Liver Disease

K. L. PUESTOW, Prof.

(1) Proctoscopy and Diseases of the Colon and Small Bowel
(2) Functional and Organic Changes of Neurogenic Origin
(3) Diseases of the Esophagus
(4) Peptic Ulcer and Related Conditions
(5) Management of the Arthritides

JOHN RANKIN, Assoc. Prof.

(1) Use of Pulmonary Function Tests in the Evaluation of Patients with Cardiopulmonary Disease
(2) Evaluation of Disability Produced by Diseases of the Lungs
(3) Pulmonary Diseases (especially diffuse pulmonary disease, industrial diseases, fungus infections, and diseases peculiar to farmers)
(4) Inhalation Therapy

G. G. ROWE, Assoc. Prof.

(1) Cardiovascular Physiology in Congenital and Acquired Heart Disease
(2) Physiology and Pharmacology of the Coronary Circulation
(3) Cardiac Disease in Pregnancy

H. H. SHAPIRO, Assoc. Clin. Prof.

(1) Electrocardiography
(2) Coronary Artery Disease
(3) Treatment of Congestive Heart Failure
(4) Cardiac Arrhythmias

JOHN L. SIMS, Prof.

(1) Peptic Ulcer
(2) Ulcerative Colitis
(3) Malabsorption Syndromes
(4) Differential Diagnosis of Jaundice
(5) Management of Hepatic Disease
(6) Functional Gastrointestinal Disorders
(7) Problems in Gastrointestinal Bleeding
(8) Management of Resistant Infections
(9) Pancreatic Disease

J. R. TALBOT, Asst. Clin. Prof.

(1) Newer Immunologic Concepts of the Pathogenesis of Several Common Diseases
(2) Eosinophilic Pneumonitis
(3) A Dynamic Concept of Hypertensive Vascular Disease
(4) Practical Management of Hay fever
(5) Allergy in Cardiovascular Disease

A. B. WEINSTEIN, Asst. Prof.

(1) Evaluation of the Hypertensive Patient
(2) Thoracic Pain, Differential Diagnosis

Neurology

F. M. FORSTER, Prof. and Chr., Dept.

(1) Epilepsy
(2) Cerebral Vascular Accidents

HENRY PETERS, Assoc. Prof. (Neuropsychiatry)

(1) Organic Brain Syndromes and the Major Psychoses
(2) Porphyria
(3) Muscular Dystrophy

E. P. ROEMER, Assoc. Clin. Prof.

(1) Recent Concepts in Epilepsy
(2) Wisconsin and Multiple Sclerosis

Obstetrics and Gynecology

RALPH CAMPBELL, Prof.

(1) The Treatment of Prolapse of the Uterus and its Associated Anatomic Lesions
(2) The Present Status of the Treatment of Uterine Cancer
(3) The Management of Prolonged Labor
(4) The Diagnosis and Management of Bleeding During Pregnancy
(5) Prenatal Care
(6) The Treatment of Uterine Fibroids
(7) The Ovarian Tumor and its Treatment
(8) The Bony Pelvis in Pregnancy

WILLIAM KIEKHOFER, Asst. Prof.

(1) Dysfunctional Uterine Bleeding
(2) New Drugs in Obstetrics and Gynecology
(3) Results in Therapy of Gynecologic Cancer

WM. V. LUETKE, Asst. Clin. Prof.

(1) Obstetric and Gynecologic Subjects

B. M. PECKHAM, Prof. and Chr., Dept.

(1) Benign Tumors and Their Management
(2) Diagnosis and Management of Cervical Carcinoma
(3) Management of Abnormal Uterine Bleeding
(4) Pelvic Endometriosis Diagnosis and Management
(5) The Ubiquitous Fibroid
(6) Pain in Gynecology

DONALD O. PRICE, Clin. Instr.

(1) Cytology in Gynecology
(2) Prolonged Labor
(3) Intracranial Hemorrhage in the Newborn

ALWIN SCHULTZ, Instr.

(1) The Use of Radioactive Isotopes in Gynecology
(2) The Diagnosis and Treatment of Carcinoma of the Female Genital Tract
(3) The Management of Ovarian Tumors

Pediatrics

W. T. BRUNS, Instr.

(1) The Hyaline Membrane Syndrome in Newborn Infants
(2) Respiratory Physiology of the Newborn Infant
(3) Cyanosis Due to Extra-Cardiac Causes in Infancy

(4) Fibrocystic Disease of the Pancreas
(5) Immunization During Childhood
(6) Accidental Poisoning in Children

T. V. GEPPERT, Asst. Clin. Prof.

(1) General Pediatric Problems
  a. Adolesence
  b. Infant Feeding
  c. Digestive Problems in Infants
  d. Common Respiratory Infections
  e. Prematurity—Problems and Care

C. E. HOPKINS, Clin. Inst.

(1) Problems of Newborn Period
(2) Erythroblastosis
(3) Infections in First Year of Life

C. C. LOBECK, Asst. Prof.

(1) The Problem of Fluid and Electrolyte Therapy in Children
(2) Hypoglycemia—Newer Aspects in Children
(3) The New Importance of Inborn Errors of Metabolism in Children
(4) Nephrotic Syndrome in Childhood
(5) Contributions of Bone to Homeostasis

K. B. McDONOUGH, Assoc. Prof.

(1) Vomiting in the Newborn and Early Infancy
(2) Convulsions in Infancy and Childhood
(3) Lesions of Bone in Infants and Children Manifested by Pain and Disability

C. W. REIQUAM, Instructor

(1) Purpuras in Childhood
(2) Anemias in Infancy

A. A. SIEBENS, Assoc. Prof.

(1) Physiologic Effects of Pulmonary Resection
(2) Pulmonary Cystic Disease: Physiologic Changes and Effects of Resection

D. W. SMITH, Asst. Prof.

(1) Hypothyroidism in Childhood
(2) Abnormalities of Sexual Differentiation
(3) Evaluation of the Child with Short Stature
(4) The Adrenogenital Syndrome
(5) Delayed Adolescence, Its Diagnosis and Management
(6) The Obese Child
(7) Cortisone, Its Indications and Complications
(8) Cryptorchidism
(9) Adolescence, a Basic Appraisal
(10) Rational Use of Thyroid Therapy

N. J. SMITH, Prof. and Chr., Dept.

(1) Jaundice in Early Life
(2) The Rh Problem
(3) Anemias in Infancy and Childhood
(4) Cancer in Early Life

F. C. STILES, Clin. Instr.

(1) Antibiotic Therapy in Children
(2) Fluid Therapy in Children

H. K. TENNEY, Clin. Prof.

(1) Preventive Psychiatry from Pediatric Viewpoint

HARRY A. WAISMAN, Prof.

(1) Newer Advances in Mental Retardation Research
(2) Recent Advances in Treatment of Cancer in Childhood
(3) Minor Disturbances in Nutrition in Infancy

EDWARD ZUPANC, Clin. Instr.

(1) General: Pediatric Subjects
(2) Specific: Diabetes in Children, Feeding of Infants, Newborn Problems, Behavior of Children

Psychiatry

HAROLD F. BORENZ, Asst. Prof., Dir. Child Psychiatry

(1) Childhood Personality Disorders
(2) Mental Retardation

C. H. FELLNER, Asst. Prof.

(1) On the Use of "Tranquilizing Drugs" in General Practice
(2) Emotion Aspects of Obesity

L. J. GANSER, Asst. Clin. Prof. & Supt. Wisconsin Diagnostic Center

(1) The Psychiatric Program of the Wisconsin Diagnostic Center

M. H. MILLER, Asst. Prof.

(1) Directions in Psychiatry
(2) Depression, Suicide and Suicidal Gestures in Medical Practice

R. E. O'CONNOR, Asst. Clin. Prof.

(1) Emotional Development of Children
(2) Handling of Children's Behavior in Medical Practice

Radiology

JOHN H. JUHL, Assoc. Prof.

(1) Dosage Factors in Diagnostic Radiology
(2) Roentgen Aspects of Pulmonary Carcinoma

R. K. LOEFFLER, Assoc. Clin. Prof.

(1) Therapeutic Radiology
(2) Natural History of Malignancies
(3) Radioisotopes for Diagnosis and Therapy

L. W. PAUL, Prof. and Chr., Dept.

(1) Roentgenologic Aspects of Chronic Arthritis
(2) X-ray Examination of the Esophagus

HALVOR VERMUND, Prof.

(1) Role of X-ray Therapy in Treatment of Breast Cancer
(2) Cobalt Beam Teletherapy
(3) Biological Effects of Radiation

(4) Radiation Therapy in the Treatment of Malignant Disease
(5) Research in Radiotherapy

Surgery

MAXINE BENNETT, Assoc. Prof.

(1) Hearing Problems

J. V. BERGER, Asst. Clin. Prof.

(1) Anything pertaining to the eye with emphasis on:

a. Diseases and Surgery of the Cornea
b. Management of Ocular Trauma
c. Ocular Imbalance in Children
d. The Eye in Relation to General Disease
e. The Eye in Relation to Diseases of the Nervous System

F. D. BERNARD, Assoc. Clin. Prof.

(1) Differential Diagnosis of Oral Lesions
(2) Treatment of Congenital and Acquired Deformities
(3) Hand Injuries
(4) Treatment of Facial Injuries
(5) Early and Late Treatment of Burns
(6) Treatment of Facial Deformities
(7) Surgical Treatment of Mandibular Prognathism
(8) Indications for and Usage of Split Thickness Skin Grafts, Tubes and Flaps
(9) Indications for Cosmetic Surgery

A. R. CURRERI, Prof., Dir. of Cancer Research

(1) Recent Developments in the Chemotherapy of Malignancies
(2) Thoracic Surgical Subjects
(3) A Practical Approach in the Treatment of Breast Lesions
(4) Treatment of Massive Gastrointestinal Hemorrhage

GORDON DAVENPORT, Clin. Instr.

(1) Differential Diagnosis of Oral Lesions
(2) Treatment of Congenital and Acquired Deformities
(3) Hand Injuries
(4) Treatment of Facial Injuries
(5) Early and Late Treatment of Burns
(6) Treatment of Facial Deformities
(7) Surgical Treatment of Mandibular Prognathism
(8) Indications for and Usage of Split Thickness Skin Grafts, Tubes and Flaps
(9) Indications for Cosmetic Surgery

F. J. DAVIS, Asst. Clin. Prof.

(1) Office Ophthalmology in General Practice

M. D. DAVIS, Asst. Clin. Prof.

(1) Retinal Detachment
(2) Glaucoma
(3) Other Aspects of Ophthalmology

JOSEPH W. GALE, Prof.

(1) Surgery in Pulmonary Disease
(2) Mediastinal Tumors
(3) Carcinoma of the Lung
(4) The Surgical Treatment of Pulmonary Tuberculosis
(5) Thoracic Trauma

W. B. HOBBINS, Clin. Instr.

(1) Encarcerated Diaphragmatic Hernia
(2) Gastric Carcinoma
(3) Surgical Treatment of Achalasia

M. J. JAVID, Assoc. Prof. (Neurosurgery)

(1) Management of Head Injuries
(2) Neurosurgical Management of Pain
(3) Management of Spinal Cord Injuries
(4) Management of Increased Intracranial Pressure
(5) Subarachnoid Hemorrhage
(6) Recent Advances in Neurosurgery or Other Neurosurgical Topics

R. D. LANGE, Asst. Clin. Prof.

(1) Something Pertaining to E.N.T.

K. E. LEMMER, Prof.

(1) Tumors of the Small Intestine
(2) Functioning Carcinoid Tumors
(3) Surgery in Diseases of the Pancreas
(4) Surgery in Peptic Ulcer
(5) Surgery in Ulcerative Colitis

J. T. MENDENHALL, Assoc. Clin. Prof.

(1) Surgery of Pulmonary Tuberculosis

FRED E. MOHS, Assoc. Prof. (Chemosurgery)

(1) External Cancer with Special Reference to Microscopically Controlled Excision by Chemosurgery
(2) Conservative Treatment of Gangrene of the Extremities with Special Reference to Chemosurgical Amputation

JOHN PHELAN, Instructor

(1) Peripheral Vascular Disease
(2) Vascular Surgery
(3) The Use of Vessel Grafting in Peripheral Vascular Disease and Injury
(4) Management of Frostbite

R. J. SAMP, Asst. Prof.

(1) The Cancer Problem in General
(2) Cancer Prevention, Forty Possible Means
(3) Cancer Diagnosis, Via Routine Check-Up
(4) Cancer Quackery, Wisconsin and Elsewhere
(5) New Approaches to Cancer Therapy
(6) Oral Cancer (illustrated)
(7) The Smoking-and-Cancer Controversy
(8) Bowel Cancer and Colostomies
(9) Tumor Registries

E. R. SCHMIDT, Prof. and Chr., Dept.

(1) Malignancies of Tongue, Jaw and Lip
(2) Tumors of the Parotid Gland
(3) Surgery of the Breast
(4) Emergency Surgery of the Abdomen

J. R. STEEPER, Clin. Instr.

(1) Polyps of Colon and Rectum: Their Detection, Treatment, and Relationship to Carcinoma
(2) Surgical Treatment of Common Ano-rectal Lesions
(3) Diagnosis and Treatment of Arterial Obstruction

H. M. SUCKLE, Asst. Clin. Prof.

(1) Epilepsy—Medical and Surgical Therapy
(2) Strokes—Diagnosis, Treatment and Prevention

C. R. TABORSKY, Assoc. Clin. Prof.

(1) Hearing Tests and Hearing Surgery

H. W. WIRKA, Prof. (Orthopaedic)

(1) Fractures of Elbow
(2) Fractures of Ankle
(3) Bone Tumors
(4) Management of Minor Foot Disturbances
(5) Knee Injuries

W. P. YOUNG, Assoc. Prof.

(1) Cardiac Surgery
(2) Current Surgical Management of Congenital and Acquired Heart Disease

Oncology

VAN R. POTTER, Prof.

(1) Biochemical Feedback Mechanisms

Cancer Research

F. J. ANSFIELD, Asst. Prof.

(1) The Role of the Family Physician in Chemotherapy of Disseminated Cancer
(2) The Treatment of Disseminated Breast Cancer and Prostatic Cancer by the Family Physician with Special Emphasis on Hormonal Therapy

Laboratory of Hygiene

W. D. STOVALL, Dir., State Lab. of Hygiene

(1) Desquamated Cytology of Cancer
(2) Virus Diseases in Wisconsin
(3) Serological Tests in the Diagnosis of Infectious Diseases with More Recent Tests in the Diagnosis of Syphilis

SUPPLEMENTARY LISTING

The following, while not directly associated with either Marquette University School of Medicine or the University of Wisconsin Medical School, have been recommended by sponsoring groups, and are available as speakers to County Medical Societies:

H. G. BAYLEY, Beaver Dam (Radiology)

(1) Radiation Exposure and Common Sense
(2) Hospital Chest X-ray Admission Programs
(3) TB Case Finding
(4) Civilian Defense: Hospital Organization and Disaster Planning
(5) What Radiation Can Accomplish in the Treatment of Cancer

RICHARD BOTHAM, Dean Clinic, Madison (Surgery)

(1) Cardiac Surgery: (a) Congenital Heart Disease: Surgical Management
(b) Acquired Valvular Disease: Surgical Management
(2) Surgery to Improve Blood Supply to the Myocardium
(3) Surgery on Patients with Coronary Insufficiency

D. A. EMANUEL, Marshfield Clinic, Marshfield (Internal Medicine)

(1) Pulmonary Function
(2) Cardiac Catheterization
(3) "Farmer's Lung"
(4) Regulation of Renal Blood Flow
(5) Treatment of Hypertension

R. H. EVERS, Rocky Knoll San., Plymouth (Internal Medicine)

(1) Present Trends in Tuberculosis and Tuberculosis Control
(2) The Combined Use of a Sanatorium for Tuberculosis and For Chronic Diseases

D. J. FREEMAN, Wausau (Internal Medicine)

(1) The Clinical Applications of Radioactive Iodine in Thyroid and Cardiac Diseases
(2) The Common Congenital Heart Lesions: Their Diagnosis and Management

R. L. GILBERT, La Crosse (Internal Medicine)

(1) Hypertension: Its Diagnosis and Treatment in Clinical Practice
(2) Common Cardiac Arrhythmias and Their Treatment
(3) Coronary Thrombosis: Its Successful Treatment in a Small General Hospital
(4) Electrocardiography: Its Application in Clinical Practice

G. G. GRIESE, Marshfield Clinic, Marshfield (Pediatrics and Cardiology)

(1) Congenital Heart Disease: Diagnosis, General Principles of Treatment (including cardiac catheterizations)
(2) Rheumatic Fever
(3) Infants of Diabetic Mothers

A. S. JACKSON, Jackson Clinic, Madison (Surgery)

(1) Goiter: Diseases of the Thyroid Gland
(2) The Acute Surgical Abdomen
(3) Tumors and Cysts of the Neck
(4) Peptic Ulcer
(5) Cholecystitis

WILLIAM KREUL, St. Luke's Hospital, Racine (Anesthesiology)

(1) Obstetrical Anesthesia
(2) Obstetrical Analgesia
(3) Spinal Anesthesia
(4) Preoperative Medication
(5) Recovery Room
(6) Anesthesia for Surgery
(7) Selection of Anesthesia
(8) Regional Anesthesia

BEN R. LAWTON, Marshfield Clinic, Marshfield (Surgery)

(1) The Treatment of Chest Injuries
(2) Biopsy Techniques in the Diagnosis of Intrathoracic Disease
(3) The Treatment of Cardiac Arrest
(4) The Diagnosis and Treatment of Carcinoma of the Lung
(5) The Diagnosis and Treatment of Bronchiectasis
(6) The Diagnosis and Treatment of Diaphragmatic Herniae
(7) The Treatment of Spontaneous Pneumothorax
(8) The Modern Treatment of Empyema

J. F. MARCH, Algoma (Internal Medicine)

(1) Rheumatic Fever
(2) Coronary Disease
(3) Fibrocystic Diseases of the Pancreas

W. J. SMILES, Ashland (Internal Medicine)

(1) Diagnosis and Treatment of Acute Myocardial Infarction
(2) Follow-Up Care of Patients with Arteriosclerotic Heart Disease
(3) Prevention and Control of Complications Following Myocardial Infarction
(4) Rheumatic Heart Disease
a. Active Rheumatic Fever in "Teen-Agers"
b. Clinical Diagnosis of Mitral Stenosis
(5) Hypertensive Cardiovascular Disease: Long-Range Objective in Management

R. P. WELBOURNE, Watertown (Surgery)

(1) Carcinoma of the Breast
(2) Early Diagnosis of Cancer
(3) Carcinoma of the Colon and Rectum

ASSOCIATED SPEAKERS' SERVICE

MENTAL RETARDATION: Through the cooperation of the Wisconsin Council for Mentally Retarded Children a number of well-qualified physician speakers will be available to county medical societies. Dr. Edward D. Schwade, Milwaukee, will secure speakers as requests are routed to the Speakers' Service, State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

MATERNAL DEATHS (As CP Conferences): Members of the Study Committee listed below are available to meet with county medical societies in review of actual cases of maternal deaths, and to conduct it as a CP conference, with active audience participation. At least one and one-half hours should be allowed for this special type of speaker service. Available speakers: T. A. Leonard, M. D. or Ben Peckham, M. D., Madison; George S. Kilkenny, M. D. or F. J. Hofmeister, M. D., Milwaukee; or William Kreul, M. D., Racine.

Direct All Speaker Requests to:

STATE MEDICAL SOCIETY OF WISCONSIN

BOX 1109, MADISON 1, WISCONSIN

THE MEDICAL FORUM

STATE AFFAIRS

MEDICAL CARE PLANS

Commission Meeting

The SMS Commission on Medical Care Plans met for the 33rd time during the last weekend in June.

Reports were made on the two-month-old Century Plan, national Blue Shield and AMA meetings.

Figures on Medicare showed that the claim volume seems to be leveling off at a slightly lower monthly total in 1959. Average month in 1958 was $34,703; in the first four months of 1959 the average was $33,800.

There was a major change made in the WPS hospital contract. Nervous and mental benefits were expanded from 60 to 120 days of care for the life of the subscriber's contract.

This combined total of days of care can either be received through a general hospital or sanitarium.

To keep SMS membership fully informed on Commission matters, a resolution was passed urging county societies to have their Councilor and Commissioner make reports to them on major WPS matters at least once a year.

Dr. E. M. Dessloch, Prairie du Chien, was re-appointed chairman and all other officers were re-elected: Dr. Robert Krohn, Black River Falls, vice chairman; Dr. N. A. Hill, Madison, WPS treasurer; Dr. W. T. Casper, Milwaukee, delegate to national Blue Shield and AMA observer. Dr. A. W. Hilker, Eau Claire, was elected as alternate.

Appointed as new Commission member was Dr. E. L. Bernhart, Milwaukee.

WPS

Legislation

Hearings have been held on Bill 907, A which would provide stricter regulation of the three nonprofit health insurance plans (Blue Cross, WPS–Blue Shield and Surgical Care).

In a statement prepared for the hearings, Gov. Gaylord A. Nelson (who had the bill introduced) said: that 907, A was designed to "protect the 1,100,000 Wisconsin residents covered by these plans."

"Under present statutes, the authority of the Insurance Commissioner is different for each of the plans and in no case is it adequate," he continued.

"Surgical Care, the plan of the Milwaukee County Medical Society is virtually exempt from any supervision by the Insurance Commissioner through a grandfather clause," Gov. Nelson said.

DR. E. M. DESSLOCH
Reappointment and Resolution.

At the present time, he pointed out, the commissioner can only require Blue Cross and WPS to file annual financial statements; examine Blue Cross not less than once every three years; assure that WPS and Blue Cross invest their assets according to regulations; require WPS to file copies of its subscriber contracts (and certain others) for approval; merely assume that the plans conform to the nondiscriminatory rate regulations in the law; assure that WPS complies with insurance laws relating to premium reserves.

Furthermore, the commissioner has no statutory authority to enforce these provisions, Nelson pointed out.

SMS, which has called for stricter insurance regulations for the past 20 years, was requested by the Governor's office to assist in drafting of the bill.

The new provisions, if passed, would:

1. Give the commissioner general power to require reports of plans.
2. Require agents of the plans to be licensed.
3. Give the commissioner authority to approve the manner of presentation as well as the form of contracts.
4. Require the plans to heed the law on unfair competition and unfair or deceptive practices.
5. Give the commissioner general rule-making power for carrying out the bill's provisions.
6. Give power to enforce the provisions in the same manner as for domestic insurance companies.

At the hearings, Robert B. Murphy, SMS legislative counsel, said: ". . . Bill 907, A is designed to be reasonable and realistic regulation. Even though the State Medical Society does not agree with all of its provisions in their present form, I am authorized to state that the Society supports that bill."

The Governor's office offered an agreed-upon substitute amendment, which would improve the bill and this was also supported by SMS.

HEALTH INSURANCE

Steelworkers Next?

A recent issue of the national AFL–CIO News hailed the AMA's action on physicians participating in group health plans as "an important and enlightened step."

It noted the number of workers now in such group plans as the United Mine Workers and the Kaiser Plan, then stated:

"The Steelworkers, now covered by a Blue Shield type of health insurance, are considering some form of prepaid group plan as part of their current negotiations."

Such a move would have a major effect on Wisconsin medicine: an estimated 15,000–17,000 steelworkers are in this state.

STATE AFFAIRS

CANCER

Questionnaire

The American Cancer Society has announced that it will provide information on individuals or organizations making unorthodox or unproved methods or products available to the public for treatment of cancer.

To gather such information, its Committee on New or Unproved Methods of Treatment of Cancer has devised a detailed questionnaire, copies of which have been sent the SMS.

For some time the SMS Committee on Cancer has had a continuous "watch" program in operation to detect unorthodox cancer treatment methods. Its efforts, combined with those of other societies in the U. S., should soon build up an invaluable central file at the national level.

FORAND BILL

Action Stations!

On July 13 Congressional hearings began on the controversial Forand Bill (H. R. 4700).

The Bill: Would amend the Social Security Act to provide hospital, nursing home and surgical services under federal contract for persons eligible for old-age and survivors' benefits.

The Cost: Estimated at $2 billion (that's $2,000,000,000.00) for the first and second years, shooting up much higher as increasing numbers came under social security.

The Payments: All who now and in the future pay social security taxes would be assessed more to pay for the plan. Already those taxes are scheduled to reach 9% of payroll (up to $4800) in the years ahead. The bill will send them higher.

The Faults: (1) Care for the older citizen calls for a cooperative attack on the problem by nurses, doctors, hospitals, social workers, insurance companies, community leaders. It requires flexibility of medical approach and technique—not the rigidity inherent in government-controlled programs.

(2) The bill is a political approach to a health problem developed by non-medical people.

(3) A nationalized program of this sort would weaken the patient physician relationship.

(4) Political abuses and administrative waste would be predictable.

The Freedom of Choice: Deceptively limited. Except in emergencies, the patient would be required to select a hospital, nursing home or surgeon under federal contract. Only certified surgeons or those who are members of accredited hospital staffs are eligible.

The Control: Fees and charges would be set by the federal government which would also administer the program.

The Effect: Every single country that has adopted similar legislation has experienced overuse and overabuse of health facilities. It would also undermine voluntary health insurance and gradually replace it.

Wisconsin physicians are urged to contact their congressmen immediately expressing their opinions on the Forand Bill. Write them in care of the House Office Building, Washington 25, D. C.

Wisconsin's Congressman John W. Byrnes (Rep. 8th district) is on the committee hearing the bill. Chairman is Cong. Wilbur Mills (Dem. Ark.).

EDUCATION

Medical Assistants

Wisconsin State Medical Assistants Society, in cooperation with the State Medical Society and the Milwaukee County Medical Society. has set up a two-year course at the Milwaukee Institute of Technology.

The course, which will begin this fall, provides a balance in secretarial skills and medical knowledge.

Completion of the course, which is open to graduates of high schools anywhere in Wisconsin, leads to the degree of associate in applied science.

APPOINTMENTS

National Foundation

The National Foundation has announced the appointment of Dr. S. M. Evans, Milwaukee, to its Health Scholarship Committee for Wisconsin.

This year the Committee will select three individuals in each of five fields (medicine, medical social work, occupational therapy, physical therapy, nursing) for the 15 scholarships. Each will receive $500 a year for four years.

Further information on the eligibility of high school and college students may be obtained from either the National Foundation, 119 E. Washington, Madison, or its local chapters.

DR. S. M. EVANS
Selections and Scholarships.

STATE AFFAIRS

MATERNAL MORTALITY institutes brought together in La Crosse (seated, l. to r.): Drs. F. J. Hofmeister, Wm. Kiekhofer, T. A. Leonard, G. S. Kilkenny; (standing, l. to r.): J. C. Fox (Council Chairman) and Wm. Kreul.

MATERNAL MORTALITY

June Institutes

The June Maternal Mortality Institutes, held this summer in Madison, La Crosse and Eau Claire, drew approximately 250 area physicians and hospital personnel.

Purpose of the teaching programs has been to report significant findings from the Maternal Mortality Survey, a project of the SMS since 1953.

This year the program covered: Catastrophic Situations in the Delivery Room, Dr. William Kreul, Racine, speaker; Care of the Pregnant Woman Over 40, Dr. George S. Kilkenny, Milwaukee; Ectopic Pregnancies, Dr. Frederick J. Hofmeister, Milwaukee; Trauma During Delivery, Dr. Thomas A. Leonard, Madison; and Infection, Dr. William Kiekhofer, Madison.

MENTAL HYGIENE

Governor's Letter

Late last month Gov. Gaylord A. Nelson wrote a letter to Wilbur J. Schmidt, Director of Public Welfare.

Nelson recalled that he had raised questions during budget hearings concerning the programs of county institutions, had since introduced an assembly bill to help establish state standards for county mental hospitals.

"I do not feel, however, that this measure is sufficient in itself," said Nelson.

He pointed out that seven out of every ten of the total of 18,500 patients now in public mental institutions in Wisconsin are in county mental hospitals and that there are an additional 4,200 residents in county and city homes.

"This system is ideally suited for the development of modern treatment of the mentally ill and aged," continued Nelson.

". . . Therefore, I am requesting your department to undertake a study of the entire county institutional system with the aim of exploring the benefits that can be realized through effective coordination of institutions operated by the state and the counties, as well as community facilities for the mentally ill and aged.

Nelson's objective: legislative recommendations for the 1961–63 session.

PHARMACEUTICALS

PR for Detailmen

Just how do some doctors feel about detailmen and how can relations between the two groups be improved?

That was the twofold question answered by Dr. Lief Erickson, Burlington, in his recent talk to Racine–Kenosha pharmaceutical detailmen.

Backed by returned questionnaires he had sent to 15 state physicians, Dr. Erickson said: detailmen should be relaxed when talking, have a thorough grasp of their products, stick to the doctor's particular field of practice.

In cooperation with local detailmen, Dr. Erickson will enlarge his original questionnaire, submit it to even more state physicians.

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STATE AFFAIRS

PRESS

Between the Lines

As editor of the editorial page of the Racine *Journal Times*, W. C. ("Tex") Reynolds occupies an influential post. Yet most of his influence in that third-largest Wisconsin city comes from his daily, chatty and widely-read front page column, "Between the Lines". The following is a recent sample:

"Suppose you were a doctor called to a hospital in the wee hours of a weekend night to treat some men seriously hurt in a crash of their own making while racing along a street at high speeds. Suppose they were drunk, cursing and non-co-operative when you set out to bind their fractures and treat their wounds.

"Suppose, too, that you had good reason to suspect that they had no money, carried no insurance and that your chances of ever collecting anything for your long night's work was probably nil.

"I asked a doctor friend if this isn't a severe strain on his sympathy and his obligations as a physician. He's true to his ethics. He won't talk. But putting myself in his place—well, put YOURself in his place, and give your own answer."

ARTHRITIS

Education Program

The Wisconsin Chapter of the Arthritis and Rheumatism Foundation is sponsoring local public arthritis education programs throughout the state this year.

The Chapter's program is twofold: 1) to spread authoritative, medically approved information; and 2) to offset wrong solutions and false cures being sold to the public.

As part of the education effort, the Chapter is offering a new 10-page booklet on arthritis to anyone requesting it. The booklet is a reprint of an article from the March, 1959, issue of *Today's Health.*

For copies write the Chapter at 756 N. Milwaukee St., Milwaukee 2.

OPTOMETRY

Elections

Northeastern Wisconsin Optometric Society elected officers recently: A. D. Duperrault, Green Bay, president; Clyde Campau, Green Bay, vice president; John Mueller, Preble, secretary-treasurer.

TWO PRESIDENTS PASS as Eisenhower of the U. S. and Gundersen of the A. M. A. chat informally on auto ride to Atlantic City convention address.

AUXILIARY

Christmas Present

Working hard to obtain a worthy present for the needy American Education Foundation, the SMS Auxiliary will sell special Christmas cards to its members and physicians throughout the state.

The handsome cards, extending a "healthful, joyful" greeting, were designed and printed free of charge by a Kaukauna craftsman, according to Auxiliary President Mrs. G. A. Behnke.

Only cost to the Auxiliary is for the envelopes and for mailing packages of cards to county auxiliaries. The cards are shipped flat so that they can be easily imprinted.

Quantity prices: one dozen cards and envelopes: $1.75; two dozen: $3.25 (saving 25¢); three dozen: $4.50 (saving 75¢).

One hundred cards cost just $10.

Orders may be placed with Mrs. G. A. Behnke, 1107 Riverside Drive, Kaukauna, or Mrs. R. T. Schmidt, A.M.E.F. Chairman, 219 Miramar Dr., Green Bay.

CIVIL DEFENSE

Marshfield Explosion

A few weeks ago the city of Marshfield experienced its first civil defense alert.

At 2 p.m. on a Saturday afternoon an "explosion" of undetermined origin rocked local St. John's school. Casualties: three "killed" and 27 "injured".

Minutes after the alarm was sounded, the city's CD and hospital disaster organizations swung into action. Doctors and nurses sped to the scene with other rescue workers. "Victims" were treated at the school and the more seriously injured were the first loaded into ambulances. Nine private vehicles, in addition to two ambulances, carried the injured to St. Joseph's Hospital where they were unloaded in an emergency reception center and evaluated.

A total of 26 minutes elapsed from the time the first victim arrived at the hospital until all had been evaluated and distributed to various treatment posts.

STATE AFFAIRS

WISCONSIN GENERAL

Service Charges for M.D.'s

Physicians and surgeons at Wisconsin General hospital who have carried on a private practice will be charged a service fee for that privilege beginning July 1, 1959.

The new University of Wisconsin budget will require a payment by such physicians and surgeons equal to five per cent of their gross income from billings to private patients.

The payment schedule, which is subject to change, is intended to cover secretarial services, office space, supplies and other costs that have been provided to those on the faculty with private patients.

HEALTH INSURANCE

Union Medical Center

District Council 48, (Milwaukee area) of the American Federation of State, County and Municipal Employes (AFL–CIO) has announced plans to build a medical center for its 6,000 members.

The union hopes to persuade the city of Milwaukee and Milwaukee county to pay into the organization's welfare fund the amounts now paid to Blue Cross and Blue Shield on behalf of local government employees.

The plan could go into effect, said John C. Zinos, executive director of the union, if half of the union's Milwaukee members agree to participate.

ELECTIONS

State Board of Nursing

Wisconsin State Board of Nursing, at its June annual meeting, elected Miss Sylvia Haubrich, Green Bay, president, and Rev. A. H. Schmeuszer, Milwaukee, vice president.

Miss Bonnie Jean Field, Milwaukee, was appointed to the Committee of Examiners for Nurses.

Appointed to the Committee of Examiners for Trained Practical Nurses were Mrs. Ethel Straw, Milwaukee (reappointment), Sister Jordan, Milwaukee, and James K. Martins, M.D., Eau Claire.

UP FRONT at A. M. A. house of delegates session was the Wisconsin delegation: (second row): Drs. W. D. Stovall, J. C. Griffith, L. O. Simenstad, R. E. Campbell (holding paper to face) and E. L. Bernhart.

PUBLIC WELFARE

County Homes Report

At the end of 1958 there were 4,186 persons in Wisconsin county and city homes and county public medical institutions.

This is an increase of 8.6% over the previous year, according to the Department of Public Welfare. More than four-fifths of these individuals were over 65; almost one fifth were over 85.

Of the total number, 66% were either bedfast, chairfast or needed extensive nursing care even though ambulatory. (In one year the bedfast and chairfast have jumped 20%.)

The need for care is usually brought on by age, but many of the individuals have impairments which may or may not be related to the aging process.

There are 421 with non-senile mental impairments, 178 who are blind or partially so, 103 who are either deaf or deaf mute and 56 considered epileptics.

Public Welfare states that many of the institutions are providing a type of nursing care which, at one time, was available only in a general hospital. Thus they can care for the aged chronically ill and disabled, but it increases the number of elders under care.

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STATE AFFAIRS

CHILDREN AND YOUTH

Federal Funds

The Division of Children and Youth, State Department of Public Welfare, has received federal funds for specially-approved projects from the U. S. Children's Bureau.

Eleven such projects are now in operation.

One reported example is an analysis of services to emotionally-disturbed children at a treatment-oriented center (Sparta) serving 95.

INSURANCE

Watchdog Committee

A proposal to create a watchdog committee to fight the rising costs of hospital and medical services was favorably received recently by trustees of health-welfare funds paying out $6 million a year in the Milwaukee and Racine areas.

The trustees of 26 funds, covering some 25,000 workers in the construction industry, were informed that benefits from the funds will increase 8% or $480,000 next year.

The call for a watchdog committee was sounded by Russell M. Tolley, Indianapolis, president of the National Conference of Health and Welfare Funds, Trustees and Administrators.

"The most serious problem the health and welfare industry faces today is not mismanagement or misappropriation of funds," Tolley told the meeting.

"The real problem is how to stop greedy members of the medical profession and inefficient hospital administrations from taking part in a pattern of draining money from your health and welfare funds," he declared.

PUBLIC WELFARE

Health Care Costs Up

Health care costs in Wisconsin public assistance programs have tripled in the past eleven years, according to the Public Welfare Department.

Today, out of every dollar granted for public aid, 34¢ goes for health care. In 1947 the figure was just 11.5¢.

PLAQUE IN PLACE as Dr. W. D. Stovall views SMS commemorative entrance named after him.

RADIO

Dental Health

The SMS, in cooperation with the Wisconsin State Dental Society recently prepared two *March of Medicine* radio tapes on dental health for broadcast over state stations.

The tapes were heard at varying times during the first three weeks in July.

POISON CONTROL

Madison

ALpine 6–6811, University Hospitals Poison Information Center, Madison.

Milwaukee

DIvision 4–7100, Poison Control Center, Children's Hospital, Milwaukee

Kenosha

OLympic 4–5311, Poison Information Center, Kenosha Hospital, Kenosha.

MEDICAL ASSISTANTS

Elections

"Good medical assistants are always wanted," said Miss Violet Owen, Stoughton, at the fifth annual convention of the Wisconsin State Medical Assistants Society, held in Eau Claire last month.

"The doctor expects the assistant to administer his office, receive patients, and assist him in the examining room as well as the routine laboratory work," continued the immediate past president of the Society.

"With increased demands in the medical profession today, doctors are more and more in need of medical assistants," Miss Owen pointed out.

The 70-some member convention elected the following officers: Mrs. Mildred Gedakovitz, Waukesha, president-elect; Miss Ester Hartwig, Ripon, recording secretary; Miss Janette Wilsman, Manitowoc, corresponding secretary; Mrs. Margaret Russell, Waukesha, treasurer.

Miss Viola Wendt, West Bend, is current president.

POLIO

Public Clinic

A public polio immunization clinic at rock bottom cost was held on June 30 in Clintonville.

In all, 508 individuals took advantage of the clinic which was sponsored by the medical and hospital staffs of the local Community hospital.

First and second polio shots were given for the cost of the vaccine itself, announced Dr. Owen E. Larson, city health officer. The charge: 75¢.

"There is so much public apathy regarding immunization for polio that something had to be done to protect that portion of the public which has received no shots or one at the most," Dr. Larson explained.

"We were primarily interested in getting to those people who have had none or just one shot, he added.

Doctors and nurses donated their time to the one-day clinic.

Latest word from R. J. Platte, hospital administrator, is that another such clinic will be held on July 28.

Chiropractor Bill Argued Loudly

Examination Device Is Called a 'Fraud' in Shouting Match at Capitol Hearing

By WILLIAM R. BECHTEL
Of The Journal Staff

Madion, Wis.—A spokesman for doctors displayed a chiropractor's black box and called it a fraud at a legislative hearing Tuesday.

Chiropractors fought back with a live demonstration of the arm of an Argyle football player, which they said they had straightened out with "six adjustments."

Assemblyman Leonard (Rep., Bayside) spoke for his bill to require chiropractors licensed in Wisconsin to attend schools offering faculties and courses comparable to those of the University of Wisconsin.

Leonard touched off a shouting match with Assemblyman Ward (Dem., New Richmond), the assembly judiciary committee chairman, when he read a news story of a girl student at an Indianapolis chiropractor school who had died of diabetes.

Leonard said the school had urged her to drop insulin and that doing so had killed her.

Displays Machine

Ward shouted that the article didn't say that. He banged his gavel and demanded that Leonard say whether it did. Leonard refused and Ward threatened to throw him out.

Leonard outlasted Ward in the yelling match, refused to answer the question and swung into a display of a "neurolinometer," seized by the federal pure food and drug administration at the Toftness clinic at Cumberland (Barron county) on Jan. 9, 1958.

Ward said Leonard could not discuss this machine. Leonard shouted that Ward was afraid of it. Ward finally gave in, saying, "Go ahead with your circus performance."

Leonard said that a chiropractor operating the machine takes a metal spoon at the end of a wire with one hand and rubs it over a patient's back, while holding the fingers of his other hand on a bakelite plate, covered with powder, on the face of the machine.

Fingers Become Sticky

When the fingers become sticky on the one hand it means that the spoon in the other hand is passing over a troubled area of the anatomy, Leonard said.

He got the machine from the "quack library" of the State Medical Society of Wisconsin. Leonard said. The federal government has pronounced it a fraud, he said.

He dismantled the black box to show that the two main dials on the face of the machine, which looks like an early day radio, were not connected to anything.

Leonard said this machine showed why the educational standards of chiropractors should be raised. Ward threatened to impound the machine, but Leonard wouldn't give it to him.

The article reprinted on this page appeared first in the Milwaukee *Journal* on Wednesday, July 1, 1959. Permission was obtained to reprint it in full.

L. S. Toftness, Amery, a chiropractor, gave the rebuttal.

"I would not divulge what I know about that instrument," Toftness said. "I would rather leave them dumb. But if anybody would like to know the answer to the two dials that are not hooked up, I will give it to them."

Ward said the committee would like to know.

Toftness replied by attacking a "big wheel" which he said included doctors, druggists and the federal pure food and drug administration.

"You take this wheel and turn it against a cult, as they term us, and it becomes an octopus with tentacles as big as a boa constrictor," Toftness said.

Toftness said that the machine was not used to diagnose disease but in "research to determine pressure readings in the spine."

"Cervical and Base"

"The two dials were used for notating," he said. "They were put on there to remember what our readings were, cervical and base."

[Asked by a reporter later to explain further, Toftness said one dial was labeled "cervical" and the other "base." The operator would get a "reading" by running the metal spoon over the patient. He would set one dial to conform to this reading, then he would turn the other dial until he lost the reading, Toftness said.

[Toftness didn't want to divulge any more details about the machine because "we have a man from Columbia university who worked on radar for years who says it's all right."]

"The instrument is no longer in use for we could not compete with what we call a part of this octopus," Toftness said. "Has this country become a place where we cannot research any more? Can't a man invent machines and make up names for them. We will stand on our merits."

"Show Them the Arm"

Toftness declined to answer when a committee member asked if he could cure cancer. He introduced M. J. Gonstead, Monroe chiropractor, who displayed X-rays of his patients. One showed a doubled up arm. Gonstead said it had belonged to a football player whom doctors couldn't cure.

Then he showed an X-ray of the straightened arm.

"How did you straighten that out, by manipulating the spine?" demanded Assemblyman Timmerman (Rep., Milwaukee).

"Yes, sir, I never touched his arm, replied Gonstead, "And here he is right here."

Up jumped Harlow Kipfer of Argyle, now a Madison barber, who bore witness to Gonstead's cure.

"Show them the arm," called out Gonstead. Kipfer waved his arm. "Six adjustments!" exclaimed Gonstead.

A reporter tried to question Kipfer later, but was cut off when Kenneth Luedtke, Madison chiropractor, told the youth not to answer any questions. Kipfer was whisked from the room.

On the merits of the bill, Toftness said that UW courses in chemistry, physics, anatomy and other subjects were not suited to a course in chiropractic. He said that UW did not accept courses taught in chiropractic schools and the chiropractic schools do not accept courses at the university.

Stephen Gavin, jr., Madison, opposed the bill on behalf of the state medical society, saying it didn't go far enough.

The senate has already killed a similar bill.

STATE OF WISCONSIN

[Jt. Res. No. 42, S.]

No.————, 1959

A JOINT RESOLUTION

Relating to the issuance of a series of commemorative stamps on the theme of traffic safety.

WHEREAS, the commemorative postage stamp has been used effectively as a device to focus the attention of the American people on great problems in our nation; and

WHEREAS, the tragic loss of life and property resulting from traffic accidents is one of the great problems facing the American people; and

WHEREAS, the State Medical Society of Wisconsin has proposed that the Post Office Department issue a series of annual commemorative postage stamps during the next 5 years in an effort to stimulate in the motorists an awareness of the need for improved driving habits by the American people; now, therefore, be it

Resolved by the senate, the assembly concurring, That the legislature of the state of Wisconsin endorse this proposal of the State Medical Society of Wisconsin; and, be it further

Resolved, That copies of this resolution be submitted to the Honorable A. E. Summerfield, Postmaster General of the United States, and to the members of the Wisconsin delegation in Congress.

SPEAKER OF THE ASSEMBLY. PRESIDENT OF THE SENATE.

CHIEF CLERK OF THE ASSEMBLY. CHIEF CLERK OF THE SENATE.

TRAFFIC SAFETY STAMP resolution passes state legislature and officers of both houses affix signatures: Assembly Speaker George S. Molinaro, Senate President Philleo Nash, Assembly Chief Clerk Norman C. Anderson, and Senate Chief Clerk Lawrence R. Larsen.

MEDICAL WORLD

OPTOMETRY

AMA Study

The American Medical Association meeting in Atlantic City, authorized a thorough study of the "relation of medicine to optometry from the standpoint of the public interest."

The action came about upon the appeal of Ralph O. Rychener, M.D., Memphis, Tennessee, delegate from the section on ophthalmology.

Doctor Rychener pointed out that in the establishment of optometry as a licensed occupation, the refracting opticians sought recognition on the grounds that their activities were concerned with optics.

At that time, they said that "A lens treats light, not the eye". The term "optometry" was used precisely in the sense in which it was defined by the physician, Landolt, who introduced this term, namely the measurement of the refraction of the eye.

In practice, Doctor Rychener charged, an appreciable number of optometrists appear to deviate from this concept, "with resultant public confusion as to the functions and qualifications of the optometrist relative to those of the physician."

In approving the study, the House of Delegates declared that "this problem with respect to the eye is a major one."

EDUCATION

Trainee Program

The Public Health Service reported on the status of its new special traineeship program in neurological and sensory disorders.

Since its inception, 163 persons have received one to three years of training at 48 U. S. institutions and 16 foreign ones.

For further information write the National Institutes of Health, Bethesda 15, Maryland.

MEETINGS

World Conference

Meeting in Chicago recently, a group of prominent medical leaders discussed plans for the Second World Conference on Medical Education.

The Conference is scheduled for August 29-September 4 of this year in Chicago and will be sponsored by international bodies of medicine, including the World Medical Association.

PHARMACY

The Good Old Days

For a thousand years (until recently) Egyptians added a few drops of distilled orange flower water to their drinking water to purify it and render it more digestible.

An old Hindu remedy for whooping cough called for the ground tooth of a tiger.

In Mississippi, hog's hoof tea was formerly prescribed for colds and pneumonia.

Beauties of old Venice tried to make their hair golden by washing it in white wine and rhubarb.

State Medical Society
of Wisconsin

HOUSE OF DELEGATES REPORT MAY 1959

The House of Delegates is the legislative body of the State Medical Society. Delegates are charged with the responsibility of guiding and directing the policy and activities of the Society for the best interests of the people of Wisconsin and the medical profession.

The following pages are devoted to detailed reports of the activities of the Councils, Commissions, Divisions and the Committees of the Society, which were presented at the 118th annual meeting in Milwaukee, May 4, 5 and 6, 1959.

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REPORT OF THE COUNCIL

JAMES C. FOX, M. D.
Chairman

In 1958, the Council met in March, May, June, July, mid-September and again at the end of the same month, and finally in December for a total of seven meetings. Minutes were published in the *Wisconsin Medical Journal*, except the December meeting at which the following matters were presented (minutes of this meeting appear elsewhere in this issue):

Because of the necessity of evaluating activities under direction of the Committee on Hospital Relations, a special detailed report was considered by the Council so that planning for the 1959 budget could be undertaken on this subject. The House of Delegates has received essentially the same material as was reviewed by the Council in December, and its importance should be fully realized.

In connection with its mobile unit programs, the State Board of Health has added a heartometer for the recording of blood pressure. This screening program was thoroughly evaluated by the Council's Commission on State Departments, and the total subject reviewed at the December meeting with action being taken to recommend that these surveys be conducted only after approval of the county medical societies in the areas concerned.

The Wisconsin Pharmaceutical Association proposed a cooperative program of publishing information on narcotic prescriptions. After study by the Executive Committee and its favorable recommendation, the Council approved.

The Council formally recorded the resignation of J. W. Fons, M.D. in light of the failure of the special committee to secure reconsideration.

During this same meeting the Council acted on a report with reference to the constitution and bylaws of county medical societies. In July of 1958 the Council concluded that a detailed study of these documents was advisable in light of a number of considerations.

In the first place, while the constitution and bylaws of the State Medical Society calls for official filing by a county medical society of its constitution, bylaws and regulations, and amendments thereto, this has never been fully implemented and the State Society records are generally incomplete or fail to be up to date.

Another consideration arises out of the fact that county medical societies are corporations by the express provisions of Chapter 148 of the Wisconsin Statutes. Some of them have begun operational programs which appear to be potentially expensive and very possibly the Society should advise with these component units with reference to establishing their character as nonprofit and therefore not subject to income tax laws.

Another matter of concern is that apparently some of the county medical societies find no record of having established a constitution and bylaws in a manner consistent with the requirements of Chapter 148. Legal counsel for the Society together with the Secretary's office have prepared a model constitution and bylaws adaptable to most county medical societies, and quite a few societies are now studying them.

Still another subject of concern arises out of what is generally known: a multitude of meeting requirements have seriously affected many county medical societies to the point that their meetings are infrequent, sometimes but once a year, and on some occasions actually combined with other meetings not properly a part of a county medical society meeting.

Another problem relates to the adequate functioning of the county society board of directors, or board of trustees as these bodies are more commonly called. No clear line of demarcation consistent with Wisconsin corporation law has been fully developed, and this, again, is a subject which needs detailed study.

For these and other reasons, the Council has referred this entire study to its Planning Committee and hopes that substantial progress may be made in 1959 when it is possible again to resume normal activities.

At this same meeting there was discussion of action by the House of Delegates on recommendation of the Council that the constitution and bylaws of the county societies be amended in such manner as to give assurance that a county medical society will not conduct functioning programs beyond its geographic area. One county medical society was advised by its legal counsel that formal action to that end was not necessary inasmuch as the society is not now engaging in activities beyond its geographic boundaries, and that it is inherent in the structure of county medical societies that they exist for a specific area only. About six county medical societies had achieved the necessary revision at the time of this meeting, and the entire subject was laid over for later consideration inasmuch as the deadline had not been met.

A substantial amount of time was given to discussion of the press-radio code which has been reported to the House by the Council on Medical Service. This code was approved by the Council in some 12 pages of text. It is hoped that it will be in final printed form in mid-summer of 1959 and that gradually its implementation can be undertaken.

Various other administrative matters were considered by the Council in its December meeting, including a presentation by Doctors Beatty of Neenah, Habbe and Cowan of Milwaukee, as to the provision of certain specialty services in the prepaid movement. It was specifically agreed by the Council that the specialty services are medical, and that in accord with official pronouncements of the American Medical Association and others, benefits for these services should properly be included in the surgical-medical portion of any program. Assurance was given that the State Society would undertake all reasonable efforts to achieve this goal.

A comprehensive report of the Commission on Medical Care Plans, a Council committee, was presented by its chairman. This report reviewed operational aspects and details. The Council approved a recommendation of the Commission that its committee structure be determined by it, with report to the Council, of course. The prior assignment had been that committee structure of the Commission would be determined by the Council itself, and while this had been a reasonable requirement when the Commission was organized, it has since become too inflexible to permit the Commission to meet changing circumstances.

The Commission reported that Governor Orville L. Freeman of Minnesota, who addressed the opening session of the AMA in Minneapolis, asked for "the help of the leaders of the medical profession in working out a program that will most adequately meet the needs of our older citizens for health care and services of the highest quality."

"Responding to Doctor Gundersen's call for action and Governor Freeman's plea for help" in meeting the health care needs of the aged, the House of Delegates (AMA) adopted the following proposal submitted by the Council on Medical Service and endorsed by the Board of Trustees:

> "For persons over 65 years of age with reduced incomes and very modest resources, it is necessary immediately to develop further the voluntary health insurance or prepayment plans in a way that would be acceptable both to the recipients and the medical profession. The medical profession must continue to assert its leadership and responsibility for assuring adequate medical care for this group of our citizens.
>
> "Therefore, the Council on Medical Service recommends to the House of Delegates the adoption of the following proposal: That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate."

The Commission's report to the Council continued that "this subject is not new to WPS–Blue Shield. With some pride we can point out that several years ago provision was made to finance a special study by the School of Commerce of the University of Wisconsin. Other steps have been taken. However, the report of the AMA (which was followed immediately by bulletins from national Blue Shield urging implementation of AMA action) precipitates developments in this field.

"A word of caution . . . Plans should not be so hurried that the contribution to this area of their coverage fails of its objective, or completely nationalizes the program. The ingenuity which has characterized WPS–Blue Shield from its beginnings, and which has made it one of the top plans of the country in its leadership, should now characterize it once again. By no means are we ready to propose, necessarily, to accept a 'pattern of coverage, fees, and rates' to achieve 'a uniform offering'."

The Council has since been kept apprised of developments which have led to the issuance of the Century Plan, available as of May 1, 1959.

The Council approved a Commission request that official communications be forwarded to appropriate authorities relative to the extension of Surgical Care in areas other than its own. In addition, the resolution of the Dane County Medical Society adopted at the September 1958 meeting of the House was considered. It is understood that by action of the House, Blue Shield in Wisconsin is directed to become one in the sense that both plans are under final direction of the House as to policy matters. Surgical Care of Milwaukee continues as a plan franchised to that area, and to that area alone. This was confirmed by acceptance of the Commission's report.

A study of hospital insurance with the potential of developing further programs has been deferred temporarily in light of a Blue Cross-initiated special study and pending legislation in the Wisconsin Assembly and Senate.

Anticipating the possibility of legislation affecting the "Blue Plans," the Council adopted, on recommendation of its consultants, a statement of policy contained in the following paragraphs:

1. The State Medical Society initiate no supervisory or regulatory legislation for any of the Blue Plans in the 1959 session of the Wisconsin Legislature. This would not foreclose the Society from offering amendments to legislation proposed by others which were deemed necessary either to correct substantial errors in such proposed legislation, or to make possible the inclusion of the points detailed in the recommendation which follows.
2. In order to have the support of the Society, any bill or amendment relating to the supervision or regulation of the Blue Plans should contain one or more, and preferably all, of the following provisions:

(a) Formal requirement for the submission of annual reports by all plans. Blue Cross is now required to submit such a report. WPS has done so voluntarily; Surgical Care is reported to assert that it is exempt from such a requirement. This is believed a fundamental part of any minimal legislation intended to provide the constructive supervision of the Insurance Department.

(b) Approval of all contracts by the Insurance Department. Since its organization, WPS has filed all contract and other forms. Since 1945, the statute has empowered the Commissioner of Insurance to approve the form but not the content of contracts of medical care plans. While the statute does not extend to content, WPS has always been cooperative on this point. It is reported that Blue Cross and Surgical Care have filed some forms from time to time, but that Surgical Care does not feel obligated to do so. Blue Cross is not required by statute to file its forms. The Blue Plans and not the Insurance Department must retain the ultimate right to determine areas and extent of coverage.

(c) Require an examination by the Insurance Department every three years of the operations of plans under Chapter 148 (WPS and Surgical Care). The statutes now require an examination of Blue Cross at least that often, but there is no similar provision for WPS or Surgical Care.

(d) Licensure by the Insurance Department of all persons who sell or directly supervise the sale of Blue Cross or Blue Shield programs.

(e) Payment of some kind of fee in lieu of taxes. WPS has long been favorable to such an idea, but it should be worked out carefully with the insurance companies so as not to set a precedent unacceptable to them.

(f) Volunteer no public rate control, and oppose any proposal to vest this power in the Insurance Department. The chief reasons for such opposition are first, that the Blue Plans would be at a marked competitive disadvantage by comparison with the commercial companies, since the latter are not subject to rate control on health policies; second, that health legislation is subject to heavy pressures from the public because of the preoccupation of many people with their personal health problems. This can bring rates into the political arena instead of leaving them as matters of professional and competitive judgment.

The next meeting of the Council was held February 28–March 1, this year. This is the annual "business" meeting in which the Council reviews reports of its Finance Committee relative to the budget, elects officers, and takes other similar action. Some of these items have been reported through the Councilors and Officers Newsletter, in the Forum section of the *Wisconsin Medical Journal*, and in the newspapers themselves. This year marks the first occasion of implementing delegate caucuses on call of the Councilor concerned. These have been effected in all but one district, and delegates and county officers are well aware of their merit. Possibly due to this planning being undertaken on a coordinated basis for the first time, it was not possible to set up the dates of these meetings so as to permit staff and others to attend on a "trap line" basis, but this is a detail which can be worked out over a period of time and should pose no insuperable problem.

A number of pending or impending legislative matters were discussed with members of the Committee on Public Policy. A very considerable amount of time was necessitated by those items as to which there is no point in reporting in detail, inasmuch as the delegates, among others, have received substantial information this year as to legislative activities and there should be no area not generally known within the profession.

In September 1958, the Council submitted its recommendation that there be two meetings of the House of Delegates annually, one to receive progress reports, discharge the duties of election, etc., and the other to be held in various areas of the state as facilities are available, and to be an intensified business session. This recommendation is not being resubmitted at this time due to the fact that efforts are being made to re-establish the annual meeting in the fall of the year. However, delegates should understand that preferable dates in October still are not available. It is the Council's thought that once the fall date is re-established, then careful planning can be done as to a second session which will not interfere with going programs of the Society.

At this meeting President Hildebrand asked authority to appoint a committee to meet with a committee of The Medical Society of Milwaukee County to examine and attempt to correct any and all differences between the State Society and the Milwaukee County society. Discussion of this request was undertaken in executive session, and a motion was then adopted approving the president's request.

The budget was reviewed in detail, and the operating costs of the State Medical Society and its associated activities were approved. At the request of the Secretary, no changes in executive salaries were made.

A special meeting of the Council was held April 4 in consideration of many legislative problems requiring decision at policy-making level. So much of this material has been distributed to the House of Delegates by way of special reports from the Committee on Public Policy that, again, this meeting will not be reported here in detail. Furthermore, it may be that some subsequent action will be taken at the

time of the May meeting, and anything reported at this point could hardly be in greater detail than that which delegates have already received.

However, the Council does wish to impress upon the House that the wide variety of legislative matters necessitated streamlining Society activities to meet this added burden. The Secretary's office has been instructed to discontinue all routine services possible and to concentrate on representation of Society interest in much of this legislation. This has been heavily time consuming and involves expense which the Council feels should be carried by the dues structure of the State Medical Society, and that alone. It does not feel that subscribers' money paid for Blue Shield protection should be utilized in any legislative concern of such substance as now confronts the Society. These problems are in part philosophical and in part competitive. There is no justification in using funds acquired for sickness protection to engage in these legislative problems.

Finally, the Council has received and forwards to the House with its approval, the following resolution. Council action can become final only upon favorable consideration by the House:

"WHEREAS, we the undersigned are all members in good standing of the Washington–Ozaukee County Medical Society,

"WHEREAS, we constitute a majority of the Ozaukee County members of the Washington–Ozaukee County Medical Society,

"WHEREAS, we feel the problems of the Washington County members are separate and distinct from those of the Ozaukee County members,

"We, the undersigned, respectfully petition the Council of Delegates to authorize us to form a separate society to be known as the Ozaukee County Medical Society."

Respectfully submitted and signed by:
JOSEPH A. SEIDL, M.D.
ALLEN MISCH, M.D.
JOHN E. KIPPENHAN, M.D.
K. F. PELANT, M.D.
CHAS. P. KAUTH, M.D.
GEORGE F. SAVAGE, M.D.
O. W. HURTH, M.D.
JOHN F. WALSH, M.D.
ROBERT F. HENKLE, M.D.
T. D. ELBE, M.D.
R. H. DORR, M.D.
ARNOLD H. BARR, M.D.
HENRY J. KATZ, M.D.
PHILIP W. WALLESTAD, M.D.

Respectfully submitted,

JAMES C. FOX, M.D.

Chairman of the Council

REPORT OF THE SECRETARY

C. H. CROWNHART
Secretary

In twelve months' time:

3 meetings of the House of Delegates

9 meetings of the Council

74 meetings of various committees including 8 of the Committee on Public Policy

32 county and district meetings

As a result:

Preparation of agenda, and research associated with such items

Minutes of meetings

Implementation of action taken, such as bulletins instructed by the Committee on Public Policy

Drafting

Conferences

These constitute the activity of the Secretary's office. Averaging about three out of four week ends and several nights a week, and driving time, the Secretary's office is heavily committed to serving physicians generally, and many of them on specific problems in which the whole of medicine has an interest.

From these and other meetings come continuing assignments, such as:

Preparation, circulation (and periodic revision) of various guides such as the Interprofessional Code, and later in 1959 the Press-Radio-TV-Medical Profession code of ethical and scientific conduct in areas involving the medical profession

Preparation and management of weekly programs on the March of Medicine

The *Wisconsin Medical Journal*

Physician placement service

Activities of the SMS Charitable, Educational and Scientific Foundation, including:

Implementation and management of the Student Loan Fund (now totalling around $55,000—one-fourth of the total amount needed)

The Medical Museum at Prairie du Chien

Scientific Medicine and Research

NECROLOGY REPORT

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by an asterisk.

*H. C. Dallwig, Milwaukee
C. A. Dockery, South Milwaukee
*H. C. Ladewig, Milwaukee
*M. C. Dishmaker, Milwaukee
J. C. Betz, Baltimore, Md.
*Stephen Cahana, Milwaukee
R. Y. Wheelihan, W. Palm Beach, Fla.
*Adolph Soucek, Madison
S. W. Murphy, Kenosha
H. M. Trankle, Chippewa Falls
*B. J. Steves, Ft. Dodge, Iowa
*F. X. Pomainville, Wisconsin Rapids
Anthony Voskuil, Santa Barbara, Cal.
*S. N. Franklin, West Allis
M. W. Trentzsch, Highland
R. F. Lamb, Casa Grande, Ariz.
W. J. Winnemann, Milwaukee
*H. M. Walker, Dodgeville
*A. W. Johnson, Hales Corners
*E. H. Brooks, Bloomington
*H. M. Helm, Rockton, Illinois
*A. A. Hoyer, Beaver Dam
*H. B. Norviel, Phillips
*C. J. Smiles, Ashland
G. E. Coon, Milton
R. F. Braun, Wausau
M. E. Bartlett, Beloit
*C. F. Cronk, Cameron
A. M. Dorr, Wauwatosa
*G. J. Juckem, Sheboygan
*R. N. Leasum, Osseo
C. S. Carmichael, Ft. Atkinson
*H. O. Caswell, Jefferson
*J. J. Pink, Milwaukee
*M. E. Gabor, Milwaukee
M. W. Ward, Bangor
*C. J. Becker, Milwaukee
F. F. Newell, Burlington
*L. F. Corry, Menasha
R. B. Hoermann, Milwaukee
J. M. Conway, Spring Valley
*J. W. Goggins, Chilton
*F. B. Taylor, Madison
*W. P. O'Malley, Milwaukee
*J. A. Beyer, Madison
*F. E. Darling, Sr., Milwaukee
*N. J. Wegmann, Pompano Beach, Fla.
*Will Young, Ft. Atkinson
W. A. Pease, Rio
*A. F. Slaney, Oconto
*E. P. Hayes, Eau Claire
*E. L. Jewell, Loganville
*Clemens Messmer, Milwaukee
*A. J. Schmitt, Sheboygan
Francis DeSalvo, Wausaukee
E. C. Neumann, Milwaukee
C. F. Allen, Middleton
*S. R. Boyce, Gays Mills
J. G. Curtin, Houston, Texas
*R. G. Gallimore, Milwaukee
Pauline Leader, Lancaster
*E. F. McCann, Milwaukee

Historical markers, now in preparation, including the Nicholas Senn home in Milwaukee

Interim scientific programs for Councilor Districts and county medical society meetings

And other subjects:

Hospital relations program; see Report of Committee on Hospital Relations

Progressive WPS–Blue Shield, its development, growth, and research

Medicare

Home Town Care of the Veteran

The SMS Realty Corporation, the Section on Medical History and acquisitions achieved by it or other Society activities, such as:

Unique portraits of the two Wisconsin physicians who have served as presidents of the American Medical Association: Doctors Sleyster and Gundersen

The Grant County Medical Society donation of an unusual (and valuable) outdoor grill

The Dane County Medical Society donation of a commemorative entrance in honor of Doctor Stovall

The Kasten tree

Donation by Parke–Davis of a framed series of illustrations on medical history

Donation by the Woman's Auxiliary to the Dane County Medical Society of Sepia prints of presidents of the State Medical Society from Dane County

A gift of a sterling silver serving tray from the Charter Members of the Woman's Auxiliary to the Dane County Medical Society on its silver anniversary, 1958, from:

Mrs. C. W. Aageson
Mrs. James P. Dean
Mrs. Joseph Dean
Mrs. Joseph C. Dean
Mrs. Ivan Ellis
Mrs. George Ewell
Mrs. William Ganser
Mrs. Reginald Jackson
Mrs. Eugene Juster
Mrs. Lester McGary
Mrs. Roscoe McIntosh
Mrs. Edwin Schneiders
Mrs. Lindley Sprague
Mrs. Arthur Stehr
Mrs. H. N. Winn

Ex Libris Arno Luckhardt

Comstock Memorabilia

And countless other donations such as portraits of Beaumont and his family, medical instruments and papers.

Currently in progress is the development of a mosaic mural portraying the theme of medicine and its significance in Wisconsin. This mural will be located in the Council Room at the home of the State Medical

Society, and funds of more than $1,000 have been accumulated toward a total cost of probably $7,500.

The staff of the Society totals 140. The "home" is somewhat too small for this number, and rented space has been obtained to help out temporarily.

The staff itself is organized into several committees, with others being planned. Committee organization assures a staff as democratic in its advice as is possible. Committees on personnel policy, coverage programs and problems of WPS, and building services are frequently in session. Illustrating the latter's responsibility:

How shall the building be staffed on the occasion of meetings, particularly those for which the Society is not directly responsible, such as occasional meetings of the Community Welfare Council, the Auxiliary, etc.

Allocation of parking lot facilities for visitors, staff, etc.

Use of meeting facilities by other than Medical Society groups

Staff access to building during off hours, etc.

Controls on use of vaults and other security devices.

MEMBERSHIP REPORT

(As of December 31, 1958)

Members paying no dues		170
Affiliate members	59	
Military service members	34	
Honorary members	6	
Life members	52	
Transfer members	19	
Total	170	
Members paying pro rata dues (military service and new members after July 1		42
Associate members		47
Members in residency training		156
Members paying full dues		3103
Educational members		10
Total Membership		3528

It is the Secretary's belief that broad referral of managerial problems to the staff for its detailed consideration and advice results not only in a more interested staff, but encourages their sense of responsibility and team play, all to the good of the Society.

Narrow management policies result in a limited team that has no substitutes nor depth. Medicine's commitment, to the public and to itself, is too great to have a staff in which management details are contained in but a limited few, with the balance in ignorance of medicine's objectives and current problems.

Periodically, the entire staff is called in convocation to hear a discussion of medicine's concern with quackery and other matters of the day. It is our belief that an informed staff is as essential as an informed membership, or an informed Auxiliary.

With the membership count listed on this page, this report is concluded.

Respectfully submitted,

C. H. Crownhart
Secretary

REPORT OF COMMITTEE ON PUBLIC POLICY

A. A. QUISLING, M. D.
Chairman

The 1959 legislative session provides a situation almost unprecedented in the number of bills dealing with matters of concern to public health and the medical profession, the variety and broad scope of interests affected, and the significant effect of so many bills on fundamental concepts of public health protection and the well-being of the people.

This was not unanticipated. Two weeks after the 1958 Annual Meeting, the Committee on Public Policy wrote as follows to the delegates and alternate delegates:

"All of you know the critical importance of certain anticipated and pending legislation to the public health, to the preservation of high standards of medical care, and to the medical profession. . . . The facts are without value, however, unless they reach the legislature. Our failure to convey them carries the probability of severe penalty. That penalty, of course, is punitive or thoughtless legislation resulting from ignorance of those facts."

The response of the delegates, alternates and county society committees has been most admirable. The Committee on Public Policy has earnestly sought to communicate regularly and fully to all county societies, and in many instances, to the entire membership.

The Committee fully recognizes the difficulty of becoming familiar with the issues of some 120 or more bills affecting public health and medicine and, moreover, becoming articulate on a dozen bills in-

volving cultism, limited licensees and the corporate practice of medicine.

Perhaps the best method of illustrating the scope of legislation in this 1959 session is to submit the minutes of the last meeting of the Committee on Public Policy. This list does not represent all bills in which the Society has an interest, but it does discuss those of most immediate concern.

MINUTES

COMMITTEE ON PUBLIC POLICY

State Medical Society of Wisconsin

Red Circle Inn, Nashota

April 2, 1959

MEMBERS PRESENT: Drs. A. A. Quisling, Madison, Chairman; J. M. Sullivan, Milwaukee; Earl C. Quackenbush, Hartford; Robert G. Zach, Monroe; and W. B. Hildebrand, Menasha, ex officio.

MEMBER ABSENT: Dr. J. P. Conway, Milwaukee.

GUESTS PRESENT: Drs. John B. Hitz, Milwaukee, Member, Advisory Committee on Eye Care; and Max M. Smith, Madison, President, Wisconsin Psychiatric Association.

STAFF: Mr. Earl R. Thayer and Mr. S. E. Gavin.

ASSEMBLY BILLS:

129, A.—Hospitals and the Practice of Medicine:

Heard by Assembly Judiciary Committee March 3 and March 19, still in committee. SMS position, opposed.

Doctor Quisling and Doctor Hildebrand met in the afternoon of April 2 with Mr. Karl York, President of the Wisconsin Hospital Association. A basic philosophy was arrived at and will be worked on at future meetings of the two groups. Doctor Quisling was to report to the Council on Saturday and Mr. York was to discuss this with his Board and report back.

On the motion of Doctors Sullivan–Quackenbush, approved, the Public Policy Committee commends Doctors Quisling and Hildebrand for their accomplishment. Although there are many details which have to be agreed upon, the Public Policy Committee suggests to the Council that it authorize further discussions.

133, A.—Chiropractic under Workmen's Compensation:

Engrossed by the Assembly and referred to Joint Committee on Finance.

SMS position, opposed.

154, A.—Chiropractic Qualifications:

Requires an applicant for chiropractic license to present evidence of graduation from a chiropractic school which in the teaching of comparable subjects is determined to be substantially equivalent in the quality of its faculty, facilities and teaching methods to the University of Wisconsin.

Referred to the Committee on Judiciary. SMS position, no position at this time.

201, A.—Calling Non-Resident Physician as Witness:

The 1955 session of the Legislature recommended a five-day notice be given to the opposition to investigate out-of-state witnesses called as experts. The State Bar Association supported this recommendation. This is a National Association of Claimants' Attorneys' bill. The Committee voted to take the same position as in the past and oppose this bill.

222, A.—Additional Funds for Handicapped Children:

Would permit the use of certain Federal funds for the orthopedic program of the Bureau of Handicapped Children and, in addition, the use of these funds for various types of programs other than those covered by the orthopedic program.

Consideration laid over to next meeting.

319, A.—Physical Examination of School Employees:

Provides that school boards may accept proof of examination and chest x-ray taken within two years of application for employment in lieu of requiring a current examination and x-ray. The Committee requested a report from the Division on Chest Diseases. It reported:

> Inadvisable to make an issue of this bill at this time, but suggested that the SMS recommend to the Legislature that annual tuberculin tests be required of every school employee with x-ray if results are positive.

The Committee approved.

343, A.—Physical Examination of Claimants:

Requires copy of physician's report be furnished without exception to claimant or his attorney.

SMS, no position.

347, A.—Tort Immunity of Non-Profit Hospitals:

Eliminates immunity against tort liability now enjoyed by charitable, religious or eleemosynary organizations and municipal corporations. Imposes $25,000 limit on recovery.

SMS, watch initially; however, if WHA requests support, SMS will also oppose in the interest of holding the line on costs to the patient.

353, A.—Optometry:

As requested, Doctor Hitz reported for the Advisory Committee on Eye Care. He explained

that if this bill were to pass, it would outlaw the dispensing optician. It would redefine optometry to allow optometrists to engage in the treatment of eye diseases. It would make the board of examiners a public relations agency to promote optometry as a superior method of treating the eye. It would make it a criminal offense not to recommend an optometrist along with an ophthalmologist upon referrals from state agency programs.

It was approved by the Committee that this bill be opposed. The hearing on this bill is April 21 before the Committee on Public Welfare.

394, A.—Color Blindness Test for Hunting License Applicants:

Doctor Hildebrand reported that the Society has felt that a study of this subject is in order to present to the Conservation Department.

On the motion of Doctors Sullivan–Zach, carried, Mr. Gavin is instructed to appear before the Committee on Conservation for the purpose of informing them that more study is necessary.

411, A.—Scholarships to Out-of-State Schools:

Provides scholarship support to students to attend veterinary medicine, architecture or forestry schools in 1959, and starting in 1960 eligibility is extended to persons seeking training in other professional fields "in which an adequate and continuing supply of trained citizens in this state is lacking." This may involve chiropractic.

SMS position, watch.

413, A.—Establishment of Classes or Centers for the Instruction of Handicapped Children by the County or Part of the County:

Would permit a greater share of the cost of instruction in the orthopedic schools to be covered through state support.

Consideration laid over to next meeting.

416, A.—Amend "Grandfather's Clause in Treating the Sick":

Would allow about 15 individuals practicing various "specialties" at the time of the Basic Science Law in 1925 to practice today. Most are naturopaths.

SMS position, opposed.

417, A.—Calling Non–Resident Physician as Witness:

Same as 201, A. SMS position, oppose.

420, A.—Banning Fluoroscopic Machines for Shoe Fitting:

Heard by Assembly Committee on Public Welfare and recommended for passage.

It was moved by Doctors Sullivan–Quackenbush, approved, that this bill be favored for passage.

423, A.—Clinical Psychologists:

Doctor Smith reported that this bill has the backing of the National Association of Psychologists and has been introduced in many other states. He reported that in the states in which it has passed, it has not worked well.

It was reported that some of the clinical psychologists favor licensure under the board of medical examiners. They feel this is necessary to prevent some quacks from practicing in the state.

Mr. Gavin stated that if this bill were to pass, considering existing Wisconsin statutes, clinical psychologists would be prevented from practicing because Bill 423, A. specifically excludes them from treatment of the sick.

The Committee favored opposition to Bill 423, A., but Doctor Quisling requested Doctor Smith to report back to the Committee any developments which might come as a result of a meeting of the Wisconsin Psychiatric Association.

429, A.—Pharmacy; Definition of Dangerous Drugs:

At the request of the Wisconsin Pharmaceutical Association and the Wisconsin Board of Pharmacy, the Committee approved support of their request to define "dangerous drugs" in Wisconsin statutes as any drug bearing the caution legend.

430, A.—Exempting Certain Narcotic Preparations:

Exempts from the Wisconsin narcotic laws certain narcotic preparations containing no more than "2 grains of papavarine or any of its salts" and applies the same exemption to similar quantities of noscapine. The Pure Food and Drug Administration has stated that in these quantities they are not habit forming.

SMS position, support the bill.

439, A.—Statute of Limitations on Recovery From Personal Services:

This bill would remove from the two year statute of limitations the present exception for professional fees.

The author of this bill will probably withdraw it; however if he does not, it was approved by the Committee that this bill be opposed.

441, A.—Adulterated Foods:

This bill was prepared by the Department of Agriculture and is a technical bill. It applies the standard provisions and regulatory procedures of the Pure Food and Drug Administration and has been considered by experts in the field.

The Committee authorized support, if the situation requires it.

463, A.—Workmen's Compensation Coverage for Deafness:

The Advisory Committee to the Industrial Commission has submitted an agreed bill which will take precedent over this bill. Therefore, it was approved that no position be taken on this bill. However, when the approved bill is introduced, it is to be sent to the Committee on Industrial Health and the Division on Visual and Hearing Defects for their consideration.

470, A.—Definition of Totally and Permanently Disabled Persons:

The present definition sets up the requirement that a person must have a physical impairment. The word "physical" is removed from the bill. It would be possible to obtain Federal funds under this bill for care of persons in county homes. The Committee expressed concern over the cost and determination of disability.

It was moved by Doctors Sullivan–Quackenbush that this bill be opposed, if necessary. Watch and consider at the next meeting.

485, A.—SMS Authority to Write Hospital Coverage:

Would prohibit any state or county medical society sickness care plan to embrace "hospital services." By House action, this matter is handled by advice of the Commission on Medical Care Plans to the Council.

SMS position, opposed.

507, A.—Tort Liability of Hospitals:

Provides that hospitals would be liable in event of injury or death caused by a wrongful act on the part of the hospital. The President of the Wisconsin Hospital Association requested support for the WHA's position before the Legislature in opposition to this bill. Approved.

522, A.—Tax Exemption of Medical and Hospital Association or Institutions:

Provides that tax exemption to religious, educational or benevolent associations is withdrawn as to any medical or hospital association or institution upon a finding of discrimination on account of race, color, or creed.

Consideration laid over to next meeting.

551, A.—Advisory Committees for the Blind and Deaf:

Creates advisory committees for the blind and deaf to the board of public welfare and the state superintendent of public instruction.

Consideration laid over to next meeting.

568, A.—Governor's Commission on Alcoholism:

Creates a commission of nine members, at least three of whom are to be licensed physicians, one of the latter to be a diplomate in psychiatry.

Consideration laid over to next meeting.

609, A.—Emergency Medical Service in Milwaukee:

Would permit the Board of Public Welfare upon approval by the Milwaukee County Board to contract with private and nonprofit hospitals for the use of its facilities and physicians for emergency cases.

Consideration laid over to next meeting.

Joint Resolution 42, A.—Investigation of the Operation and Charges of Hospitals:

Authorizes the Legislative Council to investigate hospitals and particularly their administration and the "alleged unfair and inequitable charges imposed on the public in some cases."

This is a matter for the Commission on Medical Care Plans and Council consideration.

SENATE BILLS:

1, S.—Mental Health Advisory Board:

SMS position, support with addition of five ex-officio members representing state departments.

2, S.—Community Mental Health Clinic Services:

SMS position, withhold action and refer entire problem to the advisory committee proposed under Bill 1, S.

3, S.—Treatment Center for Emotionally Disturbed Children:

SMS position, support with amendment to permit appointment of staff through Dean of the Medical School.

79, S.—Employment of Public Health Personnel by District School Boards:

Permits the district school board in any county to employ qualified public health nurses, licensed dentists and physicians but without supervision of local or state boards of health as is now required.

SMS position, oppose; supervision of board of health is desirable.

90, S.—Definition of Totally and Permanently Disabled Person:

Very similar to Bill 470, A.
SMS position, oppose, if necessary. Watch and consider at next meeting.

101, S.—Compensation for Employees under Workmen's Compensation:

A technical bill dealing with silicosis of the disabling and nondisabling types and concerning examining physicians and their reports.
Consideration laid over to next meeting.

127, S.—Chemical Tests for Intoxication:

Requires any court to let into the record the chemical analysis of a sample of the breath, blood or urine on the issue of intoxication.

Consideration laid over to next meeting.

177, S.—Temporary Education Certificates:

Permits renewal of such certificates not more than four times.

SMS sponsored bill. Support.

178, S.—Internship Requirement for Licensing of M.D.:

Permits applicant to write examination before internship with issuance of license withheld until completion.

SMS sponsored bill. Support.

179, S.—Chiropody Certificates:

Permits registration of chiropodists and renewal fees be sent "to the Secretary of the Board of Medical Examiners on or before January 31." Changes title of chiropody to podiatry.

SMS sponsored bill. Support.

180, S.—Temporary License to Practice Medicine:

Extends to 1963 provision to issue temporary license in event of emergency in a community.

SMS sponsored bill. Support.

194, S.—Admission to TB Sanatoria and Wisconsin General Hospital:

Authorizes the County Judge, with approval of County Board, to designate the County Department of Public Welfare to authorize admissions of patients to sanatoria or to Wisconsin General Hospital. Committee expressed concern that the paper work may interfere with quick removal of infected patient to sanatorium.

SMS position, opposed.

209, S.—Scholarships for Nursing Students:

Provides scholarships for nursing students and nursing educators.

SMS position, support.

214, S.—Amend Basic Science Law for Dentistry:

Permits acceptance of National Board of Dental Examiners certificate. This is the same as applies to physicians.

SMS position, support.

215, S.—Definition of Nursing Home:

Reduces from three to one the number of patients to be served in the definition of nursing home.

Consideration laid over to next meeting.

221, S.—Registration of Schools to Prevent Diploma Mills:

This bill requested by the Board of Regents of the University of Wisconsin and state colleges. Requires any institution acceptable for college credit to these schools to file with the State Department of Public Instruction. Object is to prevent establishment of fraudulent institutions.

Consideration laid over to next meeting.

224, S.—Opticians:

The Advisory Committee on Eye Care considered the proposals of the opticians. Doctor Hitz reported that they recommended that the same procedure be followed for licensure as with the chiropodists and physical therapists—who do not have a separate board, but rather have an examining committee which functions under the board of medical examiners. They also recommended that the present definition of a dispensing optician be continued without change. A substitute amendment to the bill has been introduced that is agreed upon by all parties.

The Advisory Committee recommended that support be given to the substitute amendment. It was approved by the Committee that the report and suggestions of the Advisory Committee be followed.

305, S.—Involuntary and Voluntary Hospitalization of Inebriates and Drug Addicts:

Provides that as to involuntary hospitalization it is sufficient that the applicant be a resident of the state rather than the county. As to voluntary hospitalization, "addiction" is broadened to include barbiturates as well as narcotics.

Consideration laid over to next meeting.

323, S.—State Board of Nursing:

Establishes fee of $25 for nurse registration for reciprocity and clarifies miscellaneous administrative procedures of the board.

Consideration laid over to next meeting.

376, S.—Out-of-State Professional School Scholarships:

Same as Bill 411, A.

SMS position, watch only.

Joint Resolution 42, S.—Endorsement of Medical Society Safety Stamp Proposal:

The Committee notes with pleasure that the Senate has passed this resolution commending the State Medical Society for its efforts to have the Postmaster General create a postage stamp on the theme of safety on the highways.

The Committee is most appreciative of the cooperation of its local committees throughout the state as well as the physicians with whom it may not have frequent, direct contact. It expresses the sincere hope that this interest will continue to grow.

Respectfully submitted,
COMMITTEE ON PUBLIC POLICY

A. A. QUISLING, M.D., Madison, *Chairman*
J. M. SULLIVAN, M.D., Milwaukee
J. P. CONWAY, M.D., Milwaukee
E. C. QUACKENBUSH, M.D., Hartford
R. G. ZACH, M.D., Monroe
W. B. HILDEBRAND, M.D., Menasha, ex officio

REPORT OF COMMITTEE ON HOSPITAL RELATIONS

S. W. HOLLENBECK, M. D.
Chairman

Introduction

During 1957, the Committee on Hospital Relations and the Council on Medical Service conducted joint studies which indicated problems in hospital administrative procedures, hospital medical staff inactivity, and a growing complication of physician–hospital relationships. Acting on their joint recommendation, the House of Delegates in October 1957 approved a proposal that "immediate steps be taken to implement full-time field service to the medical staffs of hospitals in Wisconsin."

On January 1, 1958, Mr. Chester C. Neese, a former hospital administrator at Cumberland, Wisconsin, was employed by the Society in the capacity of "Hospital Relations Consultant" to initiate the field service program.

The Committee on Hospital Relations met on January 19, 1958, and outlined a broad program of activities including:

(a) Visits to hospitals throughout the state to survey physician–hospital relation problems and gain familiarity with physicians and hospital personnel.

(b) Accumulate and review rules, regulations and bylaws of all hospital medical staffs in Wisconsin.

(c) Place special emphasis on liaison with medical staffs of hospitals so that they might be aware of the availability of assistance from the Society on a continuing or special basis.

(d) Initiate a genuine program of consultation with medical staffs.

(e) Encourage all physicians to take an active part in hospital medical staff activity.

1958 Field Service Activity Summarized

An unusual number of inquiries come from physicians and hospital administrators concerning problems within the scope of the Committee's activities. Several members of the executive staff make contacts at county society meetings and in direct relationships with physicians. However, the bulk of the activity is carried on through the efforts of the Hospital Relations Consultant.

The following is a brief resumé of his activities from January 1, 1958, to March 15, 1959:

Total Number of Hospitals Visited	90
Repeat Hospital Visits	77
Total Miles Traveled	15,005
Approximate Total Expenses (excluding salary)	$2,631.95
Number of Days in the Field	96
Cost of Maintenance Per Day (excluding salary)	$30.16

The majority of these visits result in consultation with both the hospital administrator and one or more members of the medical staff. On a number of occasions, the Consultant has met with the Board of Trustees at one of its regular meetings. Such meetings are attended upon invitation, and only with the knowledge of the medical staff.

The Committee is emphatic that the Medical Society's activity in the field of hospital relations be directed largely toward the medical staff. Contacts with administrators and Boards of Trustees are made with the advice and knowledge of the medical staff. This has been the basic philosophy of the program since it started in early 1958. The Committee emphasizes that this policy will continue so as to assure that the Society's local activities in hospital relations cannot be misinterpreted as bypassing the medical staff.

The philosophy of the field service program is to express the intent of the Society as stated by the House of Delegates in 1957: "That there rests a duty upon the medical profession to adequately play its role in those phases of hospital administrative procedures and the hospital's relation to the public that can be handled properly only through cooperation of all parties concerned."

Summary of Problems Encountered

Quite naturally, the vast majority of services requested either by the medical staff or the administrator hinge about some point of relationship between hospital administration and the medical staff. It is gratifying to note that most of these inquiries stem from genuine concern on the part of the medi-

cal staff for the quality of medical care in the hospital. In most instances open discussion, with full presentation of facts and viewpoints, and a general clearing of the channels of communication, tends to clarify the staff–administration relationship and leads to greater cooperation for the best interests of all concerned.

Medical Staff Bylaws

A considerable portion of the activity in the hospital relations field is related to medical staff bylaws. It appears that many small hospitals either have no bylaws or have bylaws which are years out of date. Bylaws appear to be in a continuous state of evaluation and revision and new problems constantly present themselves upon which the parties concerned seek advice.

Typical of the questions upon which advice is requested are: How can there be assurance of liaison between staff and board? What provisions should be made concerning emergency and temporary hospital privileges? How and to what extent should privileges be granted to dentists? How should a consulting staff be formulated? How can the bylaws be set up to make adequate provision for disciplinary action should it become necessary? When disciplinary action is indicated, how should it be initiated so as to avoid undue public and legal difficulties?

Experience indicates that many hospitals are not aware of the deficiencies of their bylaws until one or more members of the medical staff or the administrator become involved in some type of controversy. At that point, the medical staff or the administrator seeks the advice of the State Medical Society. Usually this results in an improvement of the bylaws, at least concerning the point of issue. It is obvious that a thorough program of bylaw revision is necessary within many hospitals if these difficulties are to be prevented from reaching the crisis stage in the future.

Physician Representation on Boards of Trustees

Medical staffs in many hospitals have a feeling that their views are not adequately represented before the board of trustees. In one hospital, for example, the administrator purchased a sterilizer which was totally inadequate for its use in the hospital, and adversely affected patient care. The purchase was made without consultation with the medical staff. In another case, the medical staff requested the initiation of routine chest x-rays and transferred this request to the board through the administrator. The board turned it down without hearing the viewpoint of the medical staff. In another instance, routine chest x-rays were initiated by the board without consultation of the staff, which was opposed. These, and many other cases widely varied in nature, are constant irritations among physicians in regard to the administrative–trustee relationship.

Staff Privileges for Unqualified Persons

In several situations, advice has been sought after a chiropractor had offered to donate certain sums of money toward hospital construction on the condition that he be permitted hospital privileges. These problems are closely related to whether or not the institution is a Hill–Burton hospital, whether it wishes to maintain accreditation, and how doctors of medicine can legitimately maintain their relationship in such a circumstance.

Joint Meetings

The Consultant has attended a number of joint meetings with medical staffs, administrators and boards of trustees. In one situation, the hospital had just organized a lay advisory board and asked advice as to its responsibilities and how it could perform its function most effectively. In another, a new hospital requested several meetings to discuss organization of the medical staff, purchase of equipment and general organization of the institution, delegation of responsibilities, legal obligations, etc. In another community, the hospital had lost its only physician. The board requested a thorough review of the hospital and recommendations as to how it might be reorganized with regard to physical plant, administration and general medical policy. The intent was to create a more attractive location for physicians.

Medical–Legal Forms

Medical staffs and hospital administrators have evidenced a great deal of interest in the development and use of sound medical–legal forms. For this purpose, copies of the *Wisconsin Medical Journal* of January, 1958 have been widely circulated. Frequent requests relate to the release of information to attorneys, insurance adjustors and others.

Qualifications of Personnel

Several administrators have asked: "What are the qualifications of an assistant at surgery?" Frequently such questions are asked by the administrator at the request of the medical staff. Similar questions are raised as to the qualifications of physicians to be granted certain privileges, the qualifications of nurses, x-ray technicians, anesthetists and so on.

Medical Libraries

Accreditation has brought with it requirements for medical libraries. Several hospitals and physicians have asked for information on their organization. One physician sought assistance in setting up a medical library for the entire community to serve two hospitals and the county medical society. The question was whether this should be operated by the county society or by one of the hospitals. What should it contain, who will operate it, and how?

Dots indicate the hospitals visited from January 1, 1958 to March 15, 1959

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Liaison with State and Federal Agencies

Many requests are received with regard to the availability of funds for establishment of nursing homes and the building or expansion of hospitals. Those who inquire want information on what agencies to contact and assistance in making such contacts. Frequently requests involve contacts with the Small Business Administration to determine how to obtain funds for the building of proprietary nursing homes. Several physicians in one community sought accurate information on the availability of Hill–Burton funds for their area in the face of rival reports as to the standing of the community for funds. Close liaison has been maintained with the Hospital Construction Division of the State Board of Health.

Accreditation

The medical staffs of smaller hospitals frequently present questions or problems concerning accreditation. Standards of the Joint Commission on Accreditation often seem too rigid to those concerned with the operation of smaller hospitals. Although in many instances the problems presented are resolved by a better understanding of accreditation procedures and requirements, it is true that smaller hospitals generally are faced with unusual difficulties in meeting the currently established standards for accreditation. If accreditation is sought by such hospitals, careful planning with the Joint Commission is recommended.

Radiology and Pathology Services

For many years it has been the policy of the Committee on Hospital Relations to deal on an individual basis with situations involving differences over the employment of radiologists and pathologists. In all instances, American Medical Association and State Medical Society policies declaring these services to be medical services act as the basis for negotiation. The Committee wishes to reiterate that it is specifically charged with the responsibility of receiving and considering such complaints or differences and that it is ready and willing to serve in this capacity at any time.

Hill–Burton Program

Recently the American Medical Association completed a detailed survey concerning the Hill–Burton program. The Committee reviewed this survey and believes it advisable that a similar survey be undertaken in Wisconsin with the cooperation of the State Board of Health.

Additional Services

The variety of questions coming before the Hospital Relations Consultant and the Committee on Hospital Relations, is almost unlimited. Additional problems in which the Society has been of service to medical staffs and hospital administrators include such subjects as the release of information to the press; handling of narcotics and pharmacy problems; admittance procedures; billing, credit and collection procedures; selection of hospital administrators, architects and similar personnel; professional personnel placement; tax exemption for hospitals; purchase of equipment; establishment of specifications and bidding procedures; fund raising techniques; compliance with Industrial Commission statutes, etc.

"What the Staff Expects of the Administration"

An article entitled "What the Staff Expects of the Administration" by C. P. Schlicke, M.D., Spokane, Washington, published in *Northwest Medicine*, January, 1959, provides an unusually pertinent report on physician–hospital relationships. It is recommended for reading by every physician in Wisconsin and especially by officers of medical staffs. The article is reprinted starting on page 416 by permission of *Northwest Medicine*.

Recommendations

The large number of requests for field service from both medical staffs and administrators, the enthusiasm which this program has generally been accorded is sufficient indication of the need, even urgency, for such a program. The Committee on Hospital Relations believes there is every justification for the continuation of this highly worthwhile program of Society service to its members and to the public.

It is apparent that the medical staffs of many small and medium size hospitals in particular are increasingly conscious of their role in the joint physician–hospital effort to provide adequate care for the sick. In a sense, however, they grope for the proper approach to self-government in staff matters, improved liaison with administration and governing bodies, and more adequate means of implementing their acknowledged responsibilities.

The Committee on Hospital Relations recommends that the field service program in physician–hospital relations be continued with emphasis on contact with the entire medical staff of each hospital. A substantial effort should be made to update medical staff bylaws in all hospitals.

This project would be greatly assisted by the development of a "Guide to the Preparation of Medical Staff Bylaws" designed to meet Joint Commission on Accreditation of Hospitals' standards and to conform to the Wisconsin laws.

In addition, the Committee on Hospital Relations recommends that:

(a) Regional institutes be developed for members of medical staffs, hospital trustees and administrators. Preferably this should be undertaken through joint planning with the Wisconsin Hospital Association and the Wisconsin Conference of Catholic Hospitals. In this regard attention is directed to paragraph 2, page 417, of Doctor Schlicke's article (reprinted here from *Northwest Medicine*) entitled "What the Staff Expects of the Administration."

(b) Arrangements be made to distribute the *Wisconsin Medical Journal* Blue Book issue to all general hospitals on an annual basis.

(c) A special communication be developed to chiefs of medical staffs and administrators on a periodic basis to report current problems, results of hospital relations consultant contacts, and items of special interest in relation to the medical staff and its function in the hospital.

(d) A short term project study be created on accreditation of hospitals as it affects Wisconsin. Questions and problems would be invited from the medical staffs of all hospitals. Representatives of the Joint Commission on Accreditation of Hospitals and the American Medical Association would be invited to join final discussion of the survey and to assist in developing conclusions.

(e) Undertake a review, with the State Board of Health, of the hospital construction program to analyze the effect of the Hill–Burton program on the development of hospital and related facilities in Wisconsin. Emphasis should be placed on the development of these facilities for the next fifteen to twenty-five years.

Respectfully submitted,

COMMITTEE ON HOSPITAL RELATIONS
S. W. Hollenbeck, M.D., Milwaukee, *Chairman*
W. C. Henske, M.D., Chippewa Falls
A. H. Barr, M.D., Port Washington
S. R. Beatty, M.D., Neenah
J. P. McCann, M.D., La Crosse
E. S. Olson, M.D., Racine

REPRINTED FROM *Northwest Medicine*, JANUARY, 1959

What the Staff Expects of the Administration

C. P. SCHLICKE, M. D.
Spokane, Washington

When a hospital administrator asks the question: "Just what does the staff expect of the administration?", it is of interest to canvass one's colleagues with this question. One is apt to receive such unhelpful answers as "the impossible," "attention to its own affairs," "a policy of laissez-faire." However after taking pause for reflection, some more edifying thoughts may emerge.

In the first place, the staff has a right to expect a well-managed institution. This should include a good physical plant, first-class, up-to-date equipment; competent and adequate nursing service; housekeeping service and dietetic service. These facilities are essential if the physician is to provide complete, high-level institutional medical care as economically as possible. Obviously, a doctor cannot do his best for his patients in a badly run hospital. The importance of the role played by the hospital increases steadily as medicine becomes more complex. The hospital provides the organization and environment in which the doctor may care for his patient. As science advances there is increasing attention to the physical attributes of medicine, such as buildings, equipment, technical services and greater dependence on hospital laboratories and x-ray departments. This is a mechanistic rather than an intellectual approach and it is also an expensive one. On the other hand, as a joint AMA–AHA Commission points out, the idea that the hospital should be merely a physicians workshop to supply facilities and tools to allow him to work unhampered by restrictions is untenable. The tools are too numerous, unwieldy and expensive and their use requires the coordinated efforts of many. Doctors often disagree among themselves as to which tools are needed. Accordingly, the staff must expect some degree of supervision in these matters by the administration.

Address delivered at meeting of Providence Hospital Administrators, March 12, 1958, Spokane, Washington.

Respect for Staff Prerogatives

The staff has a right to assume that its professional integrity and the privilege of independent medical decisions will be protected. The governing body should not attempt to tell doctors how to practice medicine. The professional competence and conduct of men engaged in a learned and highly technical profession can only be judged by members of that profession, their medical peers. The importance of the administration's respect for the prerogatives of the staff and the principle of self-rule cannot be overemphasized. The Sisters of Charity of Providence should understand that better than most. Consider the disastrous outcome which followed the disregard for the principle of autonomy when the first little band of missionaries from your order settled in Chile after their ill-fated venture in the Oregon Territory in 1852.*

The staff feels that it should be able to participate in decisions affecting medical practice in the

* Reference is to a rather long and involved story, well known to Sisters of Charity of Providence. Any member of the order should be able to provide information. Space does not permit further explanation here. Ed.

(continued)

hospital, and that it should be consulted in certain phases of hospital planning, construction, purchase of equipment and problems concerning certain key personnel. If supplies are purchased without consulting the people who use them, if the staff is frustrated in its request for equipment and it sees money wrongly spent, the actions can only give rise to ill-feeling. An unhappy staff is not apt to be a very efficient staff.

One of the criticisms frequently directed at a staff is the lack of interest in administrative problems and finances. This is a most unjust criticism because it is a rare administration which takes the staff into its confidence on such matters. I wish every member of our staff could have attended the meeting of hospital trustees, administrators, accountants and staff presidents with the legislators of this area, which was held last year. It would have given them a much better understanding of what big business the hospital is. Giving such information to the staff would result in far fewer unreasonable demands and in greater attempts to conserve hospital resources. Furthermore, it would be a most important step toward promoting better relations with the public and obtaining community support if the doctors were well enough informed to explain intelligently to lay people why it costs so much to be a patient in the hospital. Most of us know very little more than that a hospital does differ from a hotel, that it requires more expensive equipment, needs many specialized technicians and does not enjoy the benefit of liquor sales or the income from a swish cocktail lounge.

Frequently the heads of departments within a hospital are bitterly assailed by the staff for unsatisfactory service when in fact the fault may be administrative. The inability to hire and keep irreplaceable technical help due to petty salary disagreements may be the whole trouble, a good example of the "penny-wise, pound-foolish" principle of false economy.

Governing Body Should Be Interested

The staff feels that the governing body should always be accessible and should appreciate staff aims and problems. It should be willing to grant reasonable requests and to cooperate in educational projects and scientific research. It should be interested in the welfare of the doctors as well as of the patients—in their happiness, security and ability to provide good medical care. It should give its unqualified support to the disciplinary efforts of the staff members in their attempts to keep their house in order.

Speaking of security—this has become a very important consideration in the work world of today. Labor unions have their job rights, educators their tenure. There is an increasing feeling among physicians that hospital appointments are too vital, particularly to surgeons, to be in annual jeopardy at the pleasure of a lay board. The uncertainties of the annual appointment system lead doctors to seek more hospital affiliations than are compatible with good patient care, resident training or efficient use of the doctor's time.

Long-Term Staff Appointment

Hospital administrators are well aware that optimum patient care is conducted when a smaller number of hospitals are involved, yet few of them realize that the lack of tenure, second only to the difficulty of getting patients into a single institution, is the reason for multiple affiliations. An American College of Surgeons' Committee, looking into this matter, feels that the annual appointment system by a lay board is not consistent with the vital role of the physician in the conduct of the hospital nor with the dignity of the medical profession. It recommends that after a probationary period of annual appointment, the staff should be eligible for longer-term appointment or that at some level, senior members of the staff should get tenure. The Board of Governors of the College passed a resolution to this effect, but the Regents voted to table it. Administrators fear that, with tenure, staff members might become careless in their regard for hospital rules, their responsibilities to the hospital or even their care of patients. The tenure would not have to be absolute, but defined in terms of performance and could be terminated for cause at any time and in any event at a specified retirement age. Tenure would not mean a closed staff, but would voluntarily preclude the absurd situation of a staff having more members than its hospital has beds.

The Governing Body

Now let us consider these things from the standpoint of the various parties involved, the governing body, the administrator and the staff, and finally let us consider the problem of administration—staff relationships in general. The governing body is the supreme authority. It is morally and legally responsible for the entire conduct of the hospital. In most eleemosynary hospitals it is composed of men and women of ability and prominence, high types who are dedicated to public service and genuinely interested in the welfare of patients. They add strength to the hospital by their prestige, money-raising ability and business acumen. Lucius Johnson, writing in *Modern Hospital*, describes them as "important citizens who enjoy headaches." Unfortunately, they may have an appalling lack of information as to the problem of good medical care.

We are more fortunate in Catholic hospitals as the governing board is made up of members of a religious order whose life work has been in and about hospitals. The main contact of most governing bodies is with the administrator, seldom with

(continued)

the staff, so they may see things solely from the viewpoint of the administrator. If they are not satisfied with the total operation of the hospital, they may be sorely tempted to interfere with professional control or practice. The governing body is not competent to practice medicine or even to evaluate exactly the quality of the staff. It must be guided by the advice of the staff in such matters; this means the whole staff, not individual doctors. It should see that the staff is properly organized and governed so as to constantly improve the quality of medical care.

Since the governing body is legally responsible for staff conduct it must have the right to say who shall or shall not work in the hospital. Only by the right to exclude incompetent or undesirable individuals can the governing body be held responsible for the care of the patients. So the final responsibility of the appointment and reappointment of the staff rests upon the governing body, but it should never act without consultation with the staff or without the staff's recommendation. The right of the governing body to select the staff is recognized by law. Even in publicly supported institutions, the license to practice medicine and surgery does not automatically convey staff privileges. This would be an invasion of property rights and a menace to health standards. Furthermore, admission to the staff does not convey unlimited privileges. The rapid advancement of science and the increasing scope of medical knowledge make it impossible for anyone to be an all-around expert. The license to practice medicine does not give assurance of the qualifications of its holder. Even certification by a specialty board simply indicates that an individual has good training and is capable of carrying out certain procedures. It does not reveal what kind of a doctor he is, his sense of obligation or his degree of devotion to duty. Accordingly, admission to the staff merely conveys access to hospital facilities within the limitations of the man's training and in keeping with acceptable standards of professional conduct.

The governing body is morally responsible for operating an honest hospital and for the ethics of the staff as well as for the quality of medical care. An institution harboring abuses shares the onus of guilt with the staff. The governing body must have moral courage to face up to its duties and responsibilities. It must support the staff in its policing efforts and its classification of privileges and must back up the administrator in his decisions when they are right. The use of the authority of the governing body to enforce staff rule is one of the most important factors in improving medical care in hospitals. A good example in our own hospital is the manner in which the Surgical Committee functions, with support of the governing body, in forcing adherence to proper standards.

The Administrator

The hospital administrator occupies, to my mind, an unenviable position. His is the responsibility of coordinating the multiple activities of the professional, technical and administrative services into a smooth-running whole. His ability as a liaison officer determines the relationship, attitude, understanding and harmony between the staff and the governing body. He is directly responsible to the governing body in such matters as cost of operation, personnel, housekeeping, maintenance, expansion. Although he is generally regarded as incompetent to evaluate the quality of the staff, he shares the responsibility for the quality of medical care. In order to be successful all he has to do is to be patient, sympathetic, understanding, tactful, impartial, unbiased and, it goes without saying, competent. If he is too dictatorial, he causes dissension and exaggerates personality differences. If he is too lax, he might as well not be there.

He must have empathy with the staff and ability to see through the eyes of the doctor. In his capacity as liaison officer between the staff and the governing body he has to work with, and attempt to please, two groups of individuals of entirely different background—one professional, the other business or religious. Mr. S. G. Hill, a distinguished British administrator, has pointed out that the challenge and fascination of the health service is that the purpose for which hospitals exist—namely, the care and treatment of patients—lies entirely outside of the direct control of the administrator. In other enterprises, directors order and control in detail all of the operations under their command.

From the foregoing, it is easy to see how administrators frequently find themselves in intolerable situations which they are powerless to correct. In our recent search for a manager of the Blood Bank we were astounded at the number of hospital administrators who were at loose ends or looking for a change. Almost invariably the cause of their disaffection was that they were caught in a squeeze between the staff and the governing body.

Catholic Hospital

At this point it may be of interest to mention some conditions which are peculiar to Catholic hospitals. In these institutions the administrator is a member of, and selected by, the religious order operating the hospital. The governing body is also made up of members of the order. Their relations with the staff are often more direct and intimate than those which exist in other hospitals and as a result there may be less opportunity for misunderstanding. A potential source of friction—namely, the obligation of the Sisters to turn to their spiritual directors rather than to the staff when medical problems with moral implications arise—in practice seldom causes

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trouble. Fortunately, the decision which is right morally, almost invariably is right medically, also. Religious** are particularly vulnerable to charges of favoritism and prejudice. However, in most institutions which they operate, the staff classification and representation is on the basis of character, training, ability and merit, and the executive committee is representative of high types, both Catholic and non-Catholic; accordingly, this seldom creates a problem. One thing which goes a long way toward ironing out differences and misunderstandings is a frank discussion of medico-moral problems.

Staff Attitudes

What about the staff? It is for the most part made up of men dedicated to their work, continually learning, testing, adapting, modifying in order to render better service. These are admirable qualities, but most of them end costing the hospital money. Add to this the fact that most doctors are poor business men and it becomes essential that the administrator and governing body ride herd on them to some extent. They have behind them a long tradition of fee for service, "individual entrepreneurship," as Mr. Ray E. Brown puts it, self-sufficiency in the practice of their profession, and responsibility for direction of the total medical care of the patient.

They are at present conscious of an increasing feeling of insecurity due to the fact that they are dependent upon facilities which they do not own and personnel whom they do not employ. Modern medicine has destroyed their self-sufficiency, and their career and reputation hinge on the possession of hospital privileges. They are mortally afraid of any restrictions on their freedom in the practice of their profession—of attempts by the hospital, state or any other agency to control this practice. They view with alarm not only the spectre of socialized medicine but the continual increase in the use of full-time men by hospitals. At first, this affected only radiologists and pathologists, but gradually some hospitals began to use other specialists until finally we were confronted with the unpleasant picture of a hospital with a full-time staff, practicing medicine for a fee. If this trend continues, the medical profession will lose its independence and become a group of high-grade technicians and will not produce the best medical care. As Dwight H. Murray, former AMA President, said, "Integrity, incentive and initiative in medicine can succumb to domination and regulation by government or other groups . . . with resulting deterioration of patient care."

The function of the staff is twofold: 1) medical administrative, which means advising the governing body without attempting to usurp its rights and powers; and 2) clinical, which entails rendering proficient service to the patient, carrying on educational and research projects, periodic auditing of work done, and maintenance of efficiency. We look at our staff constitution and we find that the staff is organized primarily to ensure proper quality of medical care and treatment of patients, but also for self government, the maintenance of adequate records and making of proper recommendations to the governing body regarding applicants for appointment. It also has the responsibility of classifying the staff for major, intermediate or minor privileges, particularly in regard to surgical work. The right to control surgical work and limit the use of the operating room to those qualified entails also the responsibility of affording opportunities for training and advancement to the younger men. Staff meetings are held for the purpose of reviewing work done in the hospital. Periodic revision of the rules and upping of standards is carried out to improve patient care. All of these attempts at self-regulation are for the protection of the patient, to maintain the reputation of the hospital and to support the conscientious and ethical members of the staff. It is the obligation of the staff to maintain constant vigilance and guard against such unethical practices as ghost surgery, fee splitting, unnecessary operations, abortions and so on. When breaches of the rules are committed by some junior member of the staff, the problem is simple. However, when the culprit is one of the old guard who keeps a large complement of hospital beds filled, real moral courage, backed by the full authority of the governing board may be required. It is essential that the staff recognize the authority of the governing board to whom it is responsible for the quality and ethical character of work carried on at the hospital and, in return, it should be able to count on the full backing of the board in its attempt to achieve these aims.

Concerning staff-administration relationships, Mr. Ray E. Brown, past president of the American Hospital Association, points out that a discussion of professional relations within the hospital is a discussion of the hospital, itself. Professional activities are the sole reason for the hospital's existence and it is impossible to separate the hospital from professional practices. His conception of a modern hospital is "institutional synthesis," a bringing together by the community of all the components of medical care, professional skills, technical personnel and expensive equipment which cannot be provided by the individual physician or patient. The biggest problem in any hospital is administration-physician relationships. Mr. Milo Dean, manager of the Great Falls Clinic, feels that the human elements are the big hazards, far more important than the financial problems with which the hospital may be faced.

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** A designation commonly applied by the Sisters to themselves. The word is used as either a singular or plural noun. Ed.

Harmony Essential

Mr. Harry Harwick, of the Mayo Clinic, years ago pointed out the unfortunate tendency of the administration to become separated from the professional side with a resulting constant war between administration and staff. If the hospital exists to care for patients, it can be no bigger than its professional staff and the quality of services rendered. A close and harmonious feeling between the administration and the staff is fundamental to this end, Mr. Harwick points out, "It is a matter of confidence and mutual support." Interestingly enough, the differences which come up usually are not basic, since both sides realize that their aims are mutual. Mr. S. G. Hill admits that a hospital population is a hard group to handle. There are the V.I.P. trustees, the prima donna specialists and, as he says, a big proportion of unmarried women, many in positions of authority, who naturally constitute potentially difficult characters.

He considers that most ill-feeling and trouble arises from the lack of clarity of thought, misunderstanding, lack of personal confidence, and general suspicion based on insecurity and that the only solution is the promotion of an open, clear atmosphere. When problems arise they should be worked out at a local level by prompt negotiation without the spectacle of public conflict, litigation and vituperative statements to the press. The administration and the staff must work together smoothly or the patient will suffer. If channels of communications and relationships are not clarified and thoroughly understood, if the staff and administration are not aware of and sympathetic toward each other's problems, the result will be irritation, criticism and chaos. If communications and cooperation are good, we will see a well-managed hospital serving the best interest of the patient, the doctor and the community.

Staff Access to Governing Body

For full cooperation the staff should have direct access to the governing body. Paul R. Hawley, Director of the American College of Surgeons, says: "In too many hospitals the fence between general and professional management has no gate and the fence is too high to jump. Free access in both directions is all that is necessary for efficient hospital operation."

How is the staff to obtain direct access to the governing body, with due respect for the position of the administrator? A joint commission of the AMA and AHA to investigate this problem in 1953 suggested four alternatives: 1) a joint committee composed of the executive committee, a committee of the governing body and the administrator; 2) having a staff representative serve on the staff committee of the governing body with the administrator; 3) having a staff representative attend the governing body meetings, and 4) making it possible for members of the staff to be members of the governing body.

In the days when Malcolm MacEachern was directing the fortunes of the American College of Surgeons, that organization was very much against the last alternative. Ten categorical reasons were listed and they boiled down mainly to one word—jealousy. The Board of Governors of the American College of Surgeons last fall approved a resolution favoring staff representation on the governing body. They felt that this representation should be in a minority position; representatives should be chosen by the staff; they should serve for a limited term, and not succeed themselves for at least a year. The Regents of the College, however, tabled the resolution, feeling it was beyond their province. The American Medical Association, on the other hand, has come out in favor of staff representation on governing bodies. Since it is generally recognized that the lack of a free flow of information between the governing body and the staff has been the biggest single factor in causing serious internal strife, it may be that this is the only way that complete cooperation and understanding can be reached.

Team Work

We have been singularly fortunate in the feeling of joint enterprise and common objectives which has existed in our hospital. A good example of the resulting teamwork is the manner in which the problem of nosocomial infections was faced. The staff made a study of the problem; the administration provided an isolation ward; sterilizing and housekeeping techniques were revised; the nursing service was alerted and gave daily reports, and the problem has thus far been prevented from reaching dangerous proportions. Another example of good teamwork is the manner in which the administration and staff worked together to fulfill the requirements for approval under the accreditation program.

In closing, I can do no better than quote Sister Justina, of St. Mary's Hospital, Evansville, Indiana, who said, "In general, this problem is one of human relations demanding understanding, mutual support, forebearance and cooperation as the means of welding together the staff and the administration into a team with a single goal, the total care of the total patient."

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312 West Eighth Avenue, (4).

REPORT OF COUNCIL ON SCIENTIFIC WORK

K. E. LEMMER, M. D.
Chairman

One of the major purposes of the State Medical Society is to "extend medical knowledge and advance medical science; to elevate the standard of medical education. . . . to promote friendly intercourse among physicians . . . so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life." This is a purpose which has become well established by tradition and practice, one which the Council on Scientific Work has been proud to carry on through the development of the Annual Meeting, publication of the *Wisconsin Medical Journal*, and a number of related postgraduate educational projects.

Cooperation of Medical Groups

The Council gratefully acknowledges the cooperation of the Wisconsin Academy of General Practice and the various Wisconsin specialty groups in the development of the Annual Meeting program. Subject matter has been arranged so that all members of the Society will find material of interest. The Council is especially pleased to note the participation of many of the younger members of the Society as program speakers. It is hoped that this will continue to be a feature of future Annual Meeting programs.

Scientific Exhibits

Special attention is directed to the many fine scientific exhibits which are being provided as a part of the 1959 Annual Meeting program. Many groups and individuals have cooperated to make this scientific exhibit possible. It is hoped that all those in attendance will spend a portion of their time in study of these teaching displays which have been arranged at the auditorium.

Scientific Programs for County Societies

Hospital staff meeting requirements for accreditation, the rapid expansion of general practice and specialty postgraduate programs, and increased emphasis on socio-economic problems have combined to produce a general decline in the amount of scientific material being presented to physicians through their county medical societies. The Council on Scientific Work believes, however, that many county societies have a genuine desire to provide programs of substance and balance on both the scientific and socio-economic side. In many instances, county societies are small in membership and there is reluctance to ask a speaker to attend. Few county societies have funds available for reimbursement of speakers. This presents problems both to the society and the speaker.

To ease the financial barrier and to provide ready access to speakers, the Council on Scientific Work has established a scientific speakers service to county medical societies which will be financed through the Charitable, Educational and Scientific Foundation of the State Medical Society.

The service will receive its basic support from a $7,500 grant of State Medical Society funds to the Foundation. This will be augmented by financial support from the Wisconsin State Board of Health, the Wisconsin Division of the American Cancer Society, the Wisconsin Heart Association and the Wisconsin Anti-Tuberculosis Association.

The assistance of the Council on Scientific Work and staff members of the Society will be available throughout the ensuing year to help county societies in arranging well-balanced programs of a scientific nature.

Circuit Teaching Programs

The experience in conducting regional teaching programs in 1958–59 has suggested a modification of this type of scientific meeting. During the coming year, a single three-day circuit will be held in October in the northern section of the state. A second three-day circuit will be held in the western and central portions of the state. These programs will be arranged cooperatively with the Wisconsin Academy of General Practice so that proper credit can be secured by academy members who attend.

Special M. D.–Hospital Conferences

In cooperation with the Division on Maternal and Child Welfare, a successful series of conferences related to the Maternal Mortality Survey were presented in the year since May 1958. Three separate sessions, in Racine, Sheboygan and Appleton, were held with large attendance of physicians and hospital personnel. It is anticipated that these programs will be continued in other areas of the state during the ensuing year.

A similar type of teaching program is being arranged through the Division on Maternal and Child Welfare and the Wisconsin State Board of Health as a means of directing attention to the care of the newborn with special emphasis on prematurity.

The Wisconsin Medical Journal

The *Wisconsin Medical Journal* is one of the outstanding state medical publications in the country. Its scientific aspects are under the direction of the Editorial Board composed of Drs. R. S. Baldwin,

Marshfield, Medical Editor; D. N. Goldstein, Kenosha, Editorial Director; and Drs. D. W. Ovitt, Milwaukee; Elwood Mason, Milwaukee; Frank Weeks, Ashland; G. A. Cooper, Madison and V. S. Falk, Edgerton.

The Council notes with satisfaction the recently inaugurated changes in format which makes it easier to identify the Journal's various departments and improve the general readability of the publication. The addition of scientific "briefs" serves to improve the quality of the material presented and offers greater information on new techniques and drugs. The cooperation of the several specialty organizations in Wisconsin is being solicited to provide current reports on papers presented at local meetings.

Although scientific material for the Journal is not in short supply, members of the State Medical Society are urged to submit to the Journal articles and other reports of their clinical experience and findings. Such contributions will serve to enhance the ability of the Journal to carry out its function of education and exchange of information.

Recommendations

1. Delegates are urged to encourage county medical societies to direct additional attention to scientific programs through the use of the scientific speakers service of the State Medical Society.
2. Physicians are urged to arrange their schedules in such a way as to permit participation in the various teaching programs and physician–hospital conferences as they are announced by the Council on Scientific Work.

Respectfully submitted,

COUNCIL ON SCIENTIFIC WORK
K. E. LEMMER, M.D., Madison, *Chairman*
M. F. HUTH, M.D., Baraboo
M. C .F. LINDERT, M.D., Milwaukee
R. B. LARSEN, M.D., Wausau
R. W. FARNSWORTH, M.D., Janesville
R. S. BALDWIN, M.D., Marshfield
JOHN Z. BOWERS, M.D., Madison
J. S. HIRSCHBOECK, M.D., Milwaukee

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for listing of

SPEAKERS' SERVICE

and how it functions

REPORT OF EDITORIAL BOARD

R. S. BALDWIN, M. D.
Medical Editor

Substantial change has come over the *Wisconsin Medical Journal* in the past year. Some change has come about with recognition by the Editorial Board that simplicity of layout and a more uniform format produces greater readability in the Journal. Additional change has been indicated as the result of a membership survey of the Journal which produced some 1,400 replies. A careful analysis of our readers' comments and subsequent implementation of their suggestions has, in the opinion of the Editorial Board, produced a Journal which is a better source of scientific information, more attractive, and more readable.

The number of scientific articles in each issue has been increased partly because of the availability of many articles of excellence and partly because the readers have indicated their desire that the scientific section assume greater importance in the Journal.

The Board directs attention to the continuing publication of case reports. It believes them important as a means of conveying useful information to the readers and to stimulate scientific effort among members of the Society by encouraging them to report interesting cases.

Management of the Journal has been streamlined. The changes in format have not only improved the appearance of the Journal but have facilitated its printing and reduced certain costs.

The Board is especially pleased to note the improved quality of articles submitted for publication. Several have been abstracted in the *Journal of the American Medical Association* and a review of Journals of other states indicates that the *Wisconsin Medical Journal* is popular reading in other areas of the country.

Readers are invited to turn regularly to another new section of the Journal relating to activities in Wisconsin's two medical schools. Attention is also

directed to the addition of scientific "briefs" which offer the opportunity to localize scientific information on new drugs and techniques.

Respectfully submitted,

EDITORIAL BOARD

R. S. Baldwin, M.D., Marshfield
Medical Editor
D. N. Goldstein, M.D., Kenosha,
Editorial Director
D. W. Ovitt, M.D., Milwaukee
Elwood Mason, M.D., Milwaukee
Frank Weeks, M.D., Ashland
G. A. Cooper, M.D., Madison
V. S. Falk, M.D., Edgerton

REPORT OF COUNCIL ON MEDICAL SERVICE

D. M. WILLISON, M. D.
Chairman

Since 1951 the Council on Medical Service has, by direction of the House of Delegates, assumed responsibility for activities related to rural and industrial health in addition to the Society's public information activities. This method of combining related activities has generally worked satisfactorily. In the area of industrial health, however, the problems are of sufficient consequence and require such continuing attention as to necessitate a full-time Committee on Industrial Health.

Committee on Industrial Health

The Committee on Industrial Health is composed of: Elston Belknap, M.D., Milwaukee, Chairman; J. V. Flannery, M.D., Wausau; Gordon Peterson, M.D., Neenah; J. M. Wilkie, M.D., Madison; R. S. Wright, M.D., Racine; Thomas Burdon, M.D., Green Bay; D. E. Dorchester, M.D., Sturgeon Bay; and Donald Ruch, M.D., Milwaukee. It has worked closely with the Industrial Hygiene Division of the State Board of Health, and in particular William Lea, Ph.D., Director, Industrial Hygiene Division and Miss Katherine Chambers, R.N., Industrial Nursing Consultant.

The chairman of the Committee on Industrial Health and several members of the Committee attended the AMA Congress on Industrial Medicine in Cincinnati, Ohio, February 15–18, 1959. The Council believes that a review of this Committee's activities is important since they constitute an important service of the State Medical Society to the physicians of Wisconsin and a substantial contribution to the safety and health of industrial employees in this state.

Increased emphasis has been placed on occupational health programs in small plants. Initially, this was done through distribution of the State Medical Society's publication entitled "Occupational Health Guide for Physicians and Nurses in Industry." This guide, first prepared in 1932, went through its third revision in 1957. Almost 1,500 copies have been distributed to date, but the Committee believes that an additional 2,000 or 3,000 copies could be put to good use by small plants in Wisconsin. Promotional efforts are now being undertaken through the *Wisconsin Medical Journal*, bulletins to county medical societies and increased efforts on the part of the State Board of Health, Wisconsin Manufacturers' Association and local representatives of the National Association of Manufacturers.

Postgraduate programing for county medical societies and small plants is currently being evaluated by a special committee to determine whether to re-establish industrial health clinics and hold a symposium on the health hazards of chemicals, especially pesticides.

Another special committee has been appointed to survey small industry in Wisconsin, determine the extent of occupational health service in the state and to provide an index for future activities of the committee. This survey will not be limited to "formalized" programs in which one or more physicians serve several industrial plants. This is an effort to determine the full extent of occupational health programing in all types of industry on a full or part-time basis. The cooperation of the Wisconsin Manufacturers' Association and local representatives of the National Association of Manufacturers is being sought as well as that of state agencies in Wisconsin.

A Subcommittee on Clinical Control of Health in Industry has been appointed to undertake two studies in cooperation with the Wisconsin Industrial Commission. The Subcommittee will have a Section on Work and the Heart as a means of studying, among other things, the relationship of employment to the development of cardiac pathology. At the same time the Subcommittee will establish another Section on Periodic Physical Examinations to study possible revision of the Wisconsin Industrial Commission publication entitled "Physical Examinations of Industrial Workers" which was printed in 1939. Emphasis is to be placed on preservation of the relationship of the general practitioner to the physical examination program as a means of promoting small plant occupational health efforts.

Considerable question is arising in Wisconsin concerning the handling of narcotic drugs in industrial plants. Many physicians and nurses as well as plant officials are not aware of the proper means of handling narcotic drugs within the plant. The committee hopes to develop a clear and concise statement of policy on this problem for distribution to physicians, nurses, and industrial organizations in the state.

Close liaison is being initiated with the Industrial Medical Association District Councilor for Wisconsin and Upper-Michigan. He is invited to attend all meetings of the Committee on Industrial Health.

Medical–Press Guide

Two years of substantial effort have gone into the preparation of a guide to Medical–Hospital–Press–Radio–TV relationships. The guide has been completed and was approved by the Council of the State Medical Society at its December 13–14, 1958 meeting. The Wisconsin Hospital Association and the Wisconsin Conference of Catholic Hospitals have joined in its preparation. Copies of the guide will be distributed to all physicians, hospitals, and media of communication within Wisconsin.

The Council is proud to have played a leading role in the development of this guide for it recognizes that improved relationships between physicians and hospitals and the press can lead to better public health education and greater understanding of the profession.

Public Information

The "March of Medicine" radio progam continues as the major public information program of the State Medical Society. Its audience is estimated by reliable radio officials as something in the neighborhood of 350,000 persons per week. The State Medical Society is deeply indebted to the 39 radio stations which carry these weekly 15-minute programs as a public service feature. Each month from 200 to 400 listeners address personal inquiries to the medical director of the program, Dr. Robert C. Parkin, Assistant to the Dean at the University of Wisconsin Medical School.

A modified version of the "March of Medicine" program is utilized to provide a tape recording loan service for high school classroom teaching. Nearly 100 high schools subscribe to this service. Teachers unanimously attest the quality and usefulness of the program which includes study guides and explanatory material to assist in the presentation of the subject.

Biweekly articles are prepared for publication in the *Wisconsin Agriculturist and Farmer* which reaches into 90 per cent of the rural farm homes in Wisconsin. Monthly radio spot announcements of a health educational type are provided for public service use by all radio stations. At the same time a monthly health news bulletin is prepared for several hundred businesses and industries in the state who utilize the material in company house organs and plant bulletin boards. Other activities of the Council include the preparation of loan packets to high school and college students, loan packets to physicians, newspaper releases, lectures to student nurses and civic clubs, preparation of exhibits and distribution of health literature.

The "Personal Health Data Card" and the "Family Health Record" publications of the American Medical Association, continue to be popular items for distribution to 4–H clubs, farm bureau units, county agents and county homemakers. At least 50,000 copies of each piece of literature were distributed in Wisconsin in 1958.

The Council believes that the Society's public information programs are substantially sound and are making a major contribution to reliable public health education in Wisconsin.

Rural Health

Special emphasis has been placed by the Council on close relationship with 4-H club leaders and their activities in Wisconsin. Members of the Council meet periodically with state 4-H club leaders to plan the health programs carried on by the clubs among their 60,000 members. Through the Council an annual award of $100 is provided to a 4-H boy or girl who has demonstrated interest and activity in the field of personal, family, and community health. The winner of this award uses the $100 to help finance a trip to the National 4-H Club Congress in Chicago. At the same time the Council supervises the awarding of 30 to 40 subscriptions to *Today's Health* to clubs which have conducted outstanding programs in health and safety as part of their annual activity program. The awards are given to the club leader who in turn utilizes them for educational and project purposes.

Respectfully submitted,

COUNCIL ON MEDICAL SERVICES

D. M. Willison, M.D., Eau Claire, *Chairman*
E. C. Cary, M.D., Reedsville
J. F. Maser, M.D., Rice Lake
C. J. Picard, M.D., Superior
R. L. MacCornack, M.D., Whitehall
D. E. Dorchester, M.D., Sturgeon Bay
H. J. Kief, M.D., Fond du Lac
J. S. Devitt, M.D., Milwaukee
W. J. Fencil, M.D., Monroe

REPORT OF COMMITTEE ON CIVIL DEFENSE

E. P. LUDWIG, M. D.
Chairman

Civil defense plods ahead! Overshadowed by cold war maneuvers and obscured in the headlines of rocketry and space age scientific breakthroughs, civil defense progress continues to be made by those who realize that a little planning now will go a long way in event the "peacemakers" fail. Civil defense workers operate on the homely maxim: "Hope for the best, but prepare for the worst."

Civil defense is admittedly an unpopular topic. Lack of motivation and complacency among the general public are taken for granted even while they are damned. The Committee on Civil Defense continues to work closely with the Wisconsin Co-Director for Health Services in Civil Defense, Dr. Carl N. Neupert, and his chief assistant, Mr. Louis Remily. Civil defense resources are gradually improving and refinements continue to be made in over-all civil defense planning.

A state survival plan has been developed by the State Office of Civil Defense. Included in it is a health and medical services annex to serve as a general guide for civil defense preparations at the state and local level. The new plan incorporates the thinking of previous years and presents no major conflicts with local planning already developed.

Copies of the health and medical services annex of the state survival plan are to be sent to the secretaries of each county medical society and to each county medical director for civil defense.

The Committee has endorsed a manual prepared by the Advisory Committee on Blood Procurement, which provides the state with a workable plan for the collection of blood in the event of disaster. A vote of commendation is in order for the Advisory Committee on Blood Procurement composed of:

T. J. Greenwalt, M.D., Milwaukee, *Chairman*
Merle Owen Hamel, M.D., Madison
M. B. Llewellyn, M.D., Janesville
C. N. Neupert, M.D., Madison
W. D. Stovall, M.D., Madison
Arthur L. Van Duser, M.D., Madison

Mr. Kenneth O'Connor, Wisconsin State Field Representative, American National Red Cross, Madison

Wisconsin Hospital Association Representative to be appointed.

A total of 34 counties have appointed county medical directors for civil defense. Mobile medical teams continue to be established with 35 already fully organized, and 30 others partially organized. At least 46 teams have already received supplies.

Thirty-four 200-bed hospital units have been located in Wisconsin. Two others are being used for training purposes. The Committee notes, however, that there is a serious need for manuals to provide instruction in assembling the 200-bed units. In addition, funds are needed to help pay the cost of training selected persons in the assembly of the unit.

Radiological defense efforts in Wisconsin have been strengthened with the training of 1,800 meter readers and monitors, including 220 state agency personnel.

The Joint Commission on Accreditation of Hospitals requirement for a disaster plan in each accredited hospital has proved extremely helpful in the development of local programs.

Generally speaking, Wisconsin physicians are cooperative in civil defense activities although some are no more enthusiastic than the general populous when it comes to regular participation in training sessions or "dry runs."

Dr. C. G. Reznichek, Madison, has been named to the National Civil Defense Commission established by the American Medical Association with federal funds. He will serve as a member of a task force on the procurement of medical personnel in event of disaster.

During the past year the Committee has completed revision of a manual for mobile medical team personnel originally prepared in January, 1953. The revision brings up to date an important chapter entitled "Emergency Treatment of Disaster Casualties."

Liability protection for medical and paramedical personnel working in civil defense has been the center of considerable concern to the American Medical Association and to the Society's Committee on Civil Defense. The Committee is interested in determining, for example, the professional liability protection afforded under Wisconsin civil defense statutes to physicians and other licensed health personnel who train civil defense workers or paramedical personnel to perform essentially medical functions in a disaster situation. The Committee is also interested in learning the extent to which protection is afforded the physician for his acts performed under emergency conditions, acts which he may perform in the course of training exercises, and similar situations.

Concern has also been raised about the protection afforded civil defense workers and paramedical personnel who may, in a civil defense or other emergency, render medical or health services usually performed by licensed persons.

The Committee is currently studying these problems so that physicians may have a better understanding of their liabilities and responsibilities in these important public service efforts.

Recommendations

1. The Committee on Civil Defense recommends that the House of Delegates commend Dr. Carl N. Neupert, State Health Officer, and Mr. Louis Remily, and others of the State Board of Health staff for their continuing leadership in health and medical aspects of civil defense.

2. It is recommended that the House of Delegates urge all members of the State Medical Society to cooperate fully in the implementation of programs for civil defense which have been developed by the Committee on Civil Defense of the State Board of Health, as part of the health and medical services portion of the state survival plan. County medical societies are urged to lend official cooperation and support to such efforts.

Respectfully submitted,

COMMITTEE ON CIVIL DEFENSE

E. P. Ludwig, M.D., Wausau, *Chairman*
J. S. Wier, M.D., Fond du Lac
E. A. Bachhuber, M.D., Milwaukee
S. J. Graiewski, M.D., Oshkosh
D. L. Williams, M.D., Madison
Harold Cook, M.D., Milwaukee

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

T. L. SQUIER, M. D.
Chairman

For the first time a thorough analysis of the character of the medical profession in Wisconsin is possible through the electronic mechanisms associated with the membership records of the State Medical Society. This development has brought about the reactivation of the Committee on Medical Education and Hospitals whose projects in recent years have been handicapped by lack of fully detailed statistical information.

Based upon membership data in the Society's office on November 1, 1958, a comprehensive review of the Society's membership has been made. Many interesting facts are revealed about the membership of the Society:

Membership

There were 3,168 members of the Society on November 1, 1958. The largest of the 53 county societies is Milwaukee with 1,097 or nearly 35 per cent of the membership. The next largest is Dane with 352 members. Racine County has 107 members. The smallest county society is Juneau with four members. Twelve of the 53 county societies have fewer than 15 members. Twenty-two of the societies have between 15 and 30 members.

Age

The oldest member of the Society is 91 (born in 1867); the three youngest are age 26 (born 1932). Here is a tabulation by age bracket:

Ages	*Number*	*Per Cent*
25–35	531	17
36–45	961	31
46–55	787	25
56–65	479	15
Over 65	410	12
Totals	3,168	100

The oldest member got his license to practice in Wisconsin in 1893.

School of Graduation

Marquette University School of Medicine educated 956 of the members of the State Medical Society. In addition, 69 physicians graduated from the Milwaukee Medical College or the Wisconsin College of Physicians and Surgeons in Milwaukee, both now extinct. A total of 623 members were graduated from the University of Wisconsin Medical School. Medical schools in other states figured prominently in the Society's membership: Illinois schools produced 610 of the Society's members; Minnesota, 94; Pennsylvania, 103; New York, 80; Michigan, 58 and Iowa, 54.

Sixty-two members are graduates of foreign medical schools: 21 from Canada, 20 from Germany, one from England and one from China, for example.

Method of Practice

Fifty-two per cent of the members (1,648) practice individually. Another 1,042 are in some form of partnership or clinic practice. Two hundred seventy-three were in military service at the time of the survey. The remaining 478 were in teaching, veterans administration, public health, residency training, sanitaria or hospitals.

Type of Practice

The members were reported as engaged in 37 types of practice as follows:

Allergy	16
Medical Administration	8
Otology, Laryngology, Rhinology	27
Anesthesiology	61
Cardiovascular Diseases	19
Dermatology	43
Gynecology	5
Gastroenterology	9
General Practice	1,136
Hospital Administration	3
Internal Medicine	318
Industrial	27
Military and Government	10
Neurology	3
Neurological Surgery	14
Ophthalmology, Otology, Rhinology	99
Obstetrics	27
Obstetrics & Gynecology	164
Ophthalmology	70
Orthopedic Surgery	64
Psychiatry	63
Pathology	52
Pediatrics	103
Public Health	31
Plastic Surgery	15
Physical Medicine	5
Neurology–Psychiatry	40
Proctology	17
Professor	2
Pulmonary Diseases	23
Radiology	91
Residency	23
Research	1
Retired	38
Surgery	456
Thoracic Surgery	7
Urology	68

This information plus substantial additional detail promises to be of great assitance to the Society, to medical education and the public if properly utilized.

The Committee proposes to share this material with the Deans of both medical schools in Wisconsin. It will undoubtedly be of assistance in planning curricula, course content, postgraduate education programs and residency programs.

The study will also be shared with the State Board of Medical Examiners. That agency's reports on physician distribution and activity may also be of assistance in evaluating the Wisconsin situation.

The State Medical Society will find it of value in planning its scientific efforts and in its placement programs for physicians and communities. Careful analysis of the locations of Society members will be of considerable aid in this regard.

Based on its proposed studies the Committee plans to submit recommendations to the next session of the House.

Respectfully submitted,

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

T. L. Squier, M.D., Milwaukee, *Chairman*
I. E. Schiek, Jr., M.D., Rhinelander
J. W. Boren, Jr., M.D., Marinette
W. S. Freeman, M.D., Beloit
N. M. Clausen, M.D., Madison
John Z. Bowers, M.D., Madison
J. S. Hirschboeck, M.D., Milwaukee

REPORT OF COMMISSION ON STATE DEPARTMENTS

T. W. TORMEY, JR., M. D.
Chairman

Ten divisions of this Commission render a unique service to the membership of the State Medical Society and to the public at large by effecting a substantial degree of coordination between practicing physicians, voluntary organizations, and governmental agencies in the provision of certain medical and health services to the people of Wisconsin.

This is a unique service because the Commission on State Departments provides the mechanism under which these groups may get together for discussion of common problems. It is a means by which the State Medical Society can represent its members before state agencies and at the same time apply accepted medical principles to state and federal health programs. It is also a method by which various related but separate programs can be strengthened for the public benefit.

Perhaps these functions can best be illustrated by the simple expedient of relating the state department contacts of each division.

The Division on Nervous and Mental Diseases maintains contacts with the State Departments of Public Welfare, Public Instruction, Vocational and Adult Education, and the State Board of Health.

The Division on Public Assistance works closely with the State Department of Public Welfare and the State Board of Health.

The Division on School Health is particularly active with the State Board of Health, the Department of Public Instruction, and the State Board of Vocational and Adult Education.

The Division on Safe Transportation relates its activities to the Motor Vehicle Department, the Wisconsin Council of Safety and the University of Wisconsin Research and Safety Education Program.

The Division on Geriatrics finds its liaison with the State Board of Health, the State Department of Public Welfare, and the Governor's Commission on an Aging Population.

The Division on Visual and Hearing Defects is linked closely with the Department of Public Welfare and the Department of Public Instruction.

The Division on Handicapped Children conducts most of its activities in close cooperation with a similar division of the Department of Public Instruction.

The Division on Rehabilitation relates largely to programs of the State Department of Public Welfare, State Board of Health, and the State Board of Vocational and Adult Education.

The Division on Chest Diseases is linked to the activities of the State Board of Health and the Department of Public Welfare.

Similarly, the Division on Maternal and Child Welfare finds its closest association with the State Board of Health and the Department of Public Welfare plus the Governor's Commission on Human Rights.

In all of these activities there is an additional close association with the voluntary health organizations whose programs cover similar subjects. At the same time, coordinating relationships are maintained with the various specialty associations within the medical profession.

It is obvious that the inter-relationship of these divisions and the subjects under consideration by them provides many opportunities for unifying policy and coordinating activities to produce better, more effective service to the public.

The Commission submits herewith reports of the various divisions. They deserve the serious consideration of the House.

The Commission believes that a thorough review and analysis of the administrative rules and regulations of all state agencies whose activities involve medical and health programs would serve a useful purpose in effecting greater coordination, improved understanding and simplification of approach on many health programs. It, therefore, recommends that such a survey be undertaken during the coming year by the Commission as a whole and that its results be reported at a later session.

REPORT OF DIVISION ON NERVOUS AND MENTAL DISEASES

E. D. SCHWADE, M. D.
Chairman

Mental health legislation occupied the Division during most of 1958 and early 1959. The Division cooperated closely with the Legislative Council and its Committee and Advisory Committee on Mental Health. Literally hundreds of hours were spent by the Division members and Society staff members in conferences concerning this legislation.

At the time of writing this report, it is too early to predict the future of the three bills proposed by the Legislative Council relating to community mental health clinics, advisory board on mental health, and an intensive treatment center for emotionally disturbed children. The Society's position on all three has been made clear in hearings before the appropriate legislative committees.

Regardless of the outcome of these particular legislative proposals, the Division is anxious that the State Medical Society continue to exert its leadership and influence to the development of sound mental health programs in Wisconsin. It is imperative that mental health planning within existing state agencies and within any advisory body at an overall state level, have available to it, responsible medical advice from the State Medical Society, and in particular, representation of the psychiatric viewpoint from the profession at large. It is equally important that all practicing physicians, and particularly future classes of medical students, have available to them, and take advantage of, advanced knowledge and understanding of the emotional problems of children and adults as a most significant element in the proper total care of the patient. Efforts must be made simultaneously to better acquaint Wisconsin physicians with available facilities for the treatment of emotionally disturbed patients. Cooperative efforts should be undertaken with judges, schools, health and welfare agencies, and others to more effectively cope with emotional and psychiatric problems in a growing segment of the population.

Legislation concerning the certification of psychologists has demanded considerable attention from the Division. Again the Division recognized this legislation as but one element of the larger problem of adequate health care for the people of Wisconsin. Although the proposed psychologists' legislation presumably prohibits the treatment of the sick or the practice of medicine by those who would be certified under the bill, the Division is alarmed at certain evidences that certain psychologists are already extensively engaged in the treatment of the sick without adequate medical supervision. The Division believes that these cases should not be permitted to go unnoticed by the State Board of Medical Examiners or other law enforcement agencies. At the same time, the Division wishes to make it clear that the properly trained psychologist is an important part of the mental health team and his activity and association with proper medical direction is not only to be encouraged, but highly praised.

Liaison with voluntary groups in the mental health field requires considerable attention from the

Division and its members. Members of the Division have been assigned liaison responsibilities with the Institute on the Slow Learner, Wisconsin Council for Mentally Retarded Children, Wisconsin Epilepsy League, and the Wisconsin Cerebral Palsy Association. In this capacity the assigned physicians attend meetings of the organization in an advisory role, and the Division as a whole serves to provide advice to medical aspects of the programs planned by these organizations.

The Division is pleased to report the following meetings to which physicians are invited:

- Institute on the Slow Learner, in conjunction with the Convention of the American Association on Mental Deficiency—May 19–23, 1959, Hotel Schroeder, Milwaukee
- Wisconsin Epilepsy League—November 1959
- Wisconsin Council for Mentally Retarded Children—September 26–27, 1959
- United Cerebral Palsy of Wisconsin, Inc.—Late October

The Division has created a Subcommittee on Tranquilizers composed of E. M. Burns, M.D., Madison, Chairman; Henry Veit, M.D., Milwaukee; and T. J. Nereim, M.D., Madison. The subcommittee is preparing a statement of principles on the use and dangers of tranquilizers for submission to the *Wisconsin Medical Journal* for possible publication.

The Subcommittee on Psychiatric Residency Training is composed of Chester Wade, M.D., Milwaukee, Chairman; H. H. Reese, M.D., Madison; and L. A. Osborn, M.D., Madison. The purpose of the Subcommittee is to provide continuing review of the training programs at the University of Wisconsin Medical School and at Marquette University School of Medicine so as to encourage an expanding supply of qualified psychiatrists for the State of Wisconsin.

A Subcommittee on Commitment Laws has been re-established with Keith Keane, M.D., Appleton, Chairman; W. J. Urben, M.D., Madison; J. T. Petersik, M.D., Winnebago; T. J. Nereim, M.D., Madison; A. A. Lorenz, M.D., Eau Claire; and C. A. Wunsch, M.D., Green Bay, as members. The purpose of the Subcommittee is to review the commitment laws as they affect the procedures of admission to mental hospitals and the apparent conflict which now exists between the statutes and the needs of the community for mental health service. This review will include meetings with representatives of the County Judges Association and State Bar of Wisconsin.

In recent months the committee has become concerned over increasing evidence of questionable promotion of the use of hypnosis by non-medically trained persons. The Division is also concerned that physicians not become involved in the current flair of use of hypnosis unless they follow closely the recommendations of the American Medical Association's Council on Mental Health, adopted at the June 1958 meeting of the AMA. The Division proposes a survey of the situation in Wisconsin with special attention to the teaching of hypnosis.

Respectfully submitted,

DIVISION ON NERVOUS AND MENTAL DISEASES

E. D. Schwade, M.D., Milwaukee, *Chairman*
Henry Veit, M.D., Milwaukee
Carl L. Kline, M.D., Wausau
W. C. Lewis, M.D., Madison
Jean P. Davis, M.D., Milwaukee
A. A. Lorenz, M.D., Eau Claire
T. J. Nereim, M.D., Madison
Charles Wunsch, M.D., Green Bay
E. M. Burns, M.D., Madison
Keith Keane, M.D., Appleton
Roland Jefferson, M.D., Milwaukee
Amy Louise Hunter, M.D., State Board of Health, Madison
L. A. Osborn, M.D., Department of Public Welfare, Madison
W. J. Urben, M.D., Mendota State Hospital, Madison
J. T. Petersik, M.D., Winnebago State Hospital, Oshkosh

Special Invitee:

I. J. Sarfatty, M.D., Milwaukee Neuro–Psychiatric Society, Milwaukee

REPORT OF DIVISION ON SCHOOL HEALTH

L. M. SIMONSON, M. D.
Chairman

Positive steps to assure high immunization levels among Wisconsin pre-school and school age children are under way through a cooperative effort of the Division on School Health, Division on Maternal and Child Welfare and the State Board of Health. This action stems from several factors of concern to physicians, public health officials and the public:

. . . . Statistical reports reveal that public immunization clinics reach only a small percentage of the children aged 0–19.

. . . . It is difficult to ascertain how many children 0–4 are immunized by family physicians. There appear to be sharp differences between areas of the state.

. . . . Public controversy has developed in several areas where public clinics were about to be dropped in favor of handling all immunizations through physicians' offices.

Studies indicate there is a woeful public apathy regarding immunization, especially the DPT and polio series.

The Division recognizes the necessity for cooperative efforts by physicians, public health officials, educators and interested non-medical groups if any substantial progress is to be made toward maintaining immunization levels at a point sufficient to assure personal and public safety. To this end, the two Divisions of the Commission on State Departments and the State Board of Health herewith submit a joint special report and recommendations which, if adopted, are proposed for reprinting and distribution as a guide for local immunization efforts.

WIAA Medical Regulations

The Division's Subcommittee on WIAA is composed of the Chairman and Drs. D. W. McCormick, Fond du Lac; W. R. Manz, Eau Claire; and D. G. MacMillan, Rice Lake. In a recent review of WIAA regulations, the Subcommittee concurred with the current rule requiring three days of non-practice and non-competition after reporting to a physician because of injury. The day of injury is counted as the first day under this rule. The Division felt that conservatism is warranted and that a period of observation is wise after any injury requiring a physician's attention.

The Subcommittee also recommended that the WIAA exclude hernia from coverage in its pupil accident benefit plans.

Physicians will note with interest that several high schools will use rubber cleated shoes in all practice and competition during the 1959 football season. This will be part of a WIAA test on the control of injuries caused by metal spiked shoes.

Youth Fitness

The Division is cooperating in the 1959 Conference on Children and Youth by presenting an exhibit on youth fitness. This subject is also being emphasized through specially prepared presentations on the Society's March of Medicine Radio Program.

Athletic Injuries Conference

The first Wisconsin Conference on Athletic Injuries in Milwaukee, November 7, 1958, was highly successful with more than 700 persons attending and enthusiastic reaction to the material presented. Three other areas of the state have requested similar conferences. Plans for their implementation depend on financial support through the State Medical Society's Foundation.

Recommendations

County medical societies are urged to sponsor annual meetings of physicians with school and community representatives to discuss the proper handling of health problems affecting school students and teachers. Such a meeting is a fine public service project for the county society and one in which the State Society's Division on School Health is available to offer material assistance.

Respectfully submitted,

DIVISION ON SCHOOL HEALTH

L. M. Simonson, M.D., Sheboygan, *Chairman*
E. E. Bertolaet, M.D., West Allis
James C. H. Russell, M.D., Fort Atkinson
E. C. Hoyer, M.D., Beaver Dam
William A. Nielsen, M.D., West Bend
John G. Heisel, M.D., Superior
Amy Louise Hunter, M.D., State Board of Health, Madison

REPORT OF DIVISION ON PUBLIC ASSISTANCE

H. W. CAREY, M. D.
Chairman

Federal regulations which forced Wisconsin public assistance officials to pay the welfare recipient rather than the physician for medical services he rendered have been changed. State and county welfare agencies may again reimburse the vendor directly.

This about-face is another in a series of seesaw actions caused by Federal Social Security Act amendments and administrative regulations which tied several strings to the availability of funds for state programs.

A Federal Social Security Act amendment effective June 1, 1957, made it necessary for Wisconsin welfare departments to give up their longstanding plan of paying directly to medical vendors for their services if the state wished to qualify for some $2,000,000 in federal aid. Instead, payments had to

be made to the welfare recipient who in turn was to pay the physician, dentist or hospital. In the first year of operation under the new system, repeated complaints were heard that many recipients failed to reimburse either hospitals or physicians with the funds given them for that purpose.

The Division registered a protest with the American Medical Association, and the AMA in turn expressed its concern to Washington. While it may be assuming too much to believe that these and similar appeals were effective, the fact is that on October 1, 1958, the Wisconsin Public Assistance Division was informed that federal rules were being reversed. Since then county public assistance departments have been free to provide direct vendor payments without losing federal funds in the process.

During the past year the Division and staff members have been requested to assist several county medical societies in reviewing their relationships with county public assistance programs. Once again, the Division wishes to emphasize that a more effective public assistance program and a more harmonious relationship develops when the county medical society appoints a committee to serve in the capacity of consultants and auditors to the local welfare department.

Respectfully submitted,

DIVISION ON PUBLIC ASSISTANCE
H. W. Carey, M.D., Lancaster, *Chairman*
C. A. Olson, M.D., Baldwin
W. K. Simmons, M.D., Rhinelander
L. F. Morneau, M.D., Bear Creek
C. M. Carney, M.D., Beloit
E. W. Schacht, M.D., Racine

REPORT OF DIVISION ON SAFE TRANSPORTATION

R. S. GEARHART, M. D.
Chairman

Traffic accidents continue to take a frightening toll in death, disability and injury in Wisconsin each year. There were 822 persons killed in motor vehicle mishaps in Wisconsin in 1958. This is the lowest number of fatalities recorded in the last seven years.

There are three main factors in the production of traffic accidents: the road and other external conditions of driving, the vehicle, and the driver; and the greatest of these is the driver. While much has been done, a great deal more can be done. Physicians are in a position to lend valuable support to traffic safety measures.

A dramatic and commendable effort has been initiated by the Council of the State Medical Society of Wisconsin and this Division expresses the earnest hope that it will be adopted nationwide. This is the Council's proposal for creation of a traffic safety stamp. It has already won the endorsement of the Wisconsin Legislature and the support of many interested groups and individuals. It is hoped that these persons will join physicians around the nation in an appeal to bring about the creation of this special stamp so that millions of Americans may be reminded of their personal responsibility for safety on the highway.

The physician has a challenging duty in his role as an adviser to motorist-patients. For example, physicians should be careful to warn patients not to drive after taking various sedatives, antihistaminic, and tranquilizing drugs. They should warn patients having conditions which produce severe itching or pain, or similar disturbances that may divert a driver's attention. Other disorders such as nephritis, congenital heart disease, and leukemia present potential future hazards and physicians should keep patients with these conditions under close observation, and not hesitate to issue appropriate warnings as necessary. Persons with serious eye conditions, diabetes, hearing problems, or the loss of use of limbs should drive under specific instruction from physicians. This entire field of physician responsibility in the qualification of drivers is clearly set forth in an excellent article in *The Journal of the American Medical Association* for March 14, 1959, pages 1195–1207. It deserves reading by every physician.

The Division believes that the physician is challenged also to project his status into the wider function of medical counselor to the whole field of road safety. This can be done by expressing support of sound traffic safety programs and being as active as possible in local safety councils. Physicians can do a great deal to encourage the establishment of driver education courses in Wisconsin high schools, the installation of safety belts in automobiles, the observance of reasonable traffic and speed laws by ambulance services and by the development of adequate first aid training for ambulance drivers, firemen and police and sheriff department members.

The Division believes that "driver attitude" is in large measure responsible for the ever increasing number of motor vehicle collisions. Numerous reliable sources have drawn attention to the fact that much of the failure in past campaigns to promote safe driving has been due to the fact that, in an effort to reach the whole population by an appeal to reason, we have often reached only those who have the least need for such admonition. Safety campaigns should be devised to appeal to the emotions of the masses, and not merely to reason.

"Driver attitude" can probably be best influenced in the early years of life when other habits of living are being formed. It has been demonstrated, for example, that better training of teenage drivers is showing gratifying results. With this in mind, the Division on Safe Transportation proposes that the State Medical Society of Wisconsin institute a state-wide safe driving program aimed at securing the attention of thousands of high school age children as an integral part of safe driving education and other courses in good citizenship.

The Division recommends that the Society sponsor a contest based on the selection of a "safe driving slogan of the month". All high school students in Wisconsin would be eligible to participate and could submit as many entries as they wished. Each slogan must consist of fifteen words or less. The winning slogan would be announced at the first of each month.

High school administrators, teachers of driver education and other courses would be advised of the contest and urged to make the safe driving slogan program a part of the educational curriculum of their high schools.

To provide recognition for those who participate, a trophy would be awarded monthly to the school attended by the student whose slogan was chosen. A certificate of merit would be awarded the student whose contribution would be selected as "slogan of the month."

News media would be encouraged to publicize the slogan as a public service. Each month all newspapers would be provided with the newly selected "safe driving slogan" with the suggestion that it be used once a week, or as often as desired by the paper. The Division estimates that the annual cost of the Society of this campaign would be in the vicinity of $500 to $750.

The Division again emphasizes its belief that the most significant contribution to improved traffic safety can be made through changes in "driver attitude." To a large extent, these attitudes are developed rather than in-born.

Success in meeting the problem of ever increasing injury and death on our highways will require the cooperation of the best minds in medicine. Despite the fact that much publicity has been given to the problem, more and better publicity is needed. The Division believes that a safe driving slogan campaign properly conducted will constitute a major contribution by the State Medical Society of Wisconsin to safety on the highway.

Respectfully submitted,

DIVISION ON SAFE TRANSPORTATION

R. S. Gearhart, M.D., Madison, *Chairman*
George Anderson, M.D., Stevens Point
Milton Trautmann, M.D., Prairie du Sac
Emery M. Randall, M.D., Boscobel
James C. H. Russell, M.D., Fort Atkinson
Dayton Hinke, M.D., Richland Center
Marvin Wright, M.D., Rhinelander

REPORT OF THE DIVISION ON GERIATRICS

A. M. HUTTER, M. D.
Chairman

Almost 10% of the population of Wisconsin is 65 years of age or older. In terms of numbers alone, to say nothing of the special problems of economics, health, housing, and occupation, an increasingly aged population is deserving of the attention of all physicians.

The Division on Geriatrics attempts to focus some of this attention on specific problems and to help develop long-range plans in cooperation with others to better provide for reasonably happy and secure living for those in the older age brackets in Wisconsin.

To that end, the Chairman attended the American Medical Association Conference on the Aging in September, 1958. This was a most worthwhile and productive discussion of problems and trends in an area of growing health significance throughout the country.

In late 1958, a bill instructing the President to call a White House Conference on Aging in January, 1961, became law. This national conference is to be preceded by conferences on aging in each of the states. The purpose of these conferences is to arrive at facts and recommendations on the utilization of the skills and experiences and the improvement in general of the living conditions of older people. Congress has authorized up to $15,000.00 to help defray the expense of each state conference.

In a letter to Governor Nelson, the support of the medical profession and the services of the Society have been offered in carrying out local aspects of preparation for the White House Conference:

> "We feel it highly important that plans be initiated at an early date for the Wisconsin Conference as a preparation to the 1961 White House Conference on Aging. Conceivably, there may be a number of district conferences preceding a statewide conference. Such a development would permit participation on the part of many individuals who might otherwise be unable, perhaps for financial reasons, to attend a statewide conference which would probably involve travel, overnight expenses and etc.
>
> "The matter of adequate planning for the aged certainly is closely and intimately associated

with medicine and public health. Please be assured of the interest of the Society in any forthcoming conference which might be in your planning. You can rely upon the Society to cooperate with your office and other state agencies in perfecting a conference of wide acceptability in Wisconsin."

Progress is reported on the State Board of Health pilot project for bedridden elderly patients in nursing homes being undertaken in Brown County. After the first year, the project is serving about 70 patients in seven nursing homes. No patient is accepted without an examination and a recommendation from the individual's personal physician. Under medical supervision, the patient is evaluated for rehabilitation, and various procedures are instituted in combination with physical therapy to bring about a greater degree of self-sufficiency and self-care. Reports indicate an enthusiastic response among physicians who have participated in the program and observed the results obtainable. The Division will continue to watch the program closely and make appropriate reports to the Commission on State Departments.

The Division notes with commendation the activities of several county medical societies—Fond du Lac, Dane, and Racine—with regard to conferences and special programs for the aged. Other county societies may have undertaken such efforts, but they have not been reported to the Division. The Division encourages county society projects aimed at improving general public understanding of the needs of elderly persons.

The American Medical Association has recommended that official medical society committees dealing with geriatric problems employ the word "aging" to designate the purpose of the committees. The Division concurs in this recommendation and suggests that it would be more fitting and appropriate to term this Division a "Division on Aging."

Sincere commendation is due the Commission on Medical Care Plans of the State Medical Society for the development of its "Century Plan" of surgical-medical-hospital protection for persons over 65 through the mechanism of WPS-Blue Shield. This is a major public service achievement of the State Medical Society sponsored program, and the Division urges all physicians to give it the utmost in cooperation.

The "Rules for Construction, Maintenance, and Operation of Nursing Homes and Homes for the Aged Licensed by the State Board of Health" were recently reviewed by the Advisory Committee on Nursing Home Standards of the State Board of Health. In turn, the Division has reviewed these proposed revisions in their entirety. It is noted that important improvements have been made in rules relating to medical and health care of patients in nursing homes. In particular, the Division is pleased to report that the new rules provide that each patient or his guardian "shall designate a personal physician," that each patient in a nursing home shall have an annual physical examination, and that reasonable and practical arrangements are proposed for the health and medical care of nursing home patients.

Recommendations

1. The Division recommends that the House of Delegates authorize the State Medical Society to take an active part in the development of a statewide conference on aging prior to the White House Conference on Aging in 1961 and that the Division on Geriatrics be authorized to accept its full responsibility in the planning and conduct of regional conferences or a statewide conference to the end that medical and health aspects of the care of the aging receive due recognition and attention.
2. The Division recommends that its name be changed to "Division on Aging."
3. The Division recommends that county medical societies take a leading role in the development of local conferences designed to acquaint the aged and other persons interested in problems of the aging with all aspects of satisfactory healthful living in later years.

Respectfully submitted,

DIVISION ON GERIATRICS

A. M. Hutter, M.D., Fond du Lac, *Chairman*
Millard Tufts, M.D., Milwaukee
Walter C. Kleinpell, M.D., Kenosha
Craig Larson, M.D., Milwaukee
George M. Shinners, M.D., Green Bay
M. T. Morrison, M.D., Mount Horeb
G. G. Stebbins, M.D., Madison
Clifford Y. Wiswell, M.D., Williams Bay
B. F. Eckardt, M.D., Sheboygan
E. H. Jorris, M.D., State Board of Health, Madison

REPORT OF DIVISION ON VISUAL AND HEARING DEFECTS

GEORGE NADEAU, M. D
Chairman

Legislation affecting eye care has drawn the attention of the Division for the past several months. Bill 244, S. concerning the registration of opticians

and Bill 353, A., revising the optometry law and expanding the privileges of optometrists, have been thoroughly reviewed and opinions expressed to the Society's Committee on Public Policy through an Advisory Committee on Eye Care composed of Drs. George Nadeau, Green Bay; J. W. Doolittle, Madison; and J. B. Hitz, Milwaukee.

The Division urges that expanded educational efforts for the public and profession should be undertaken by the State Medical Society, particularly in relation to the role of optometry and opticianry in eye care. The Division points out that the legislative developments in this field, as well as the current practices of skills and trades associated with medical eye care, are of general import to the entire medical profession, not alone the ophthalmologist.

In the past year the Division has worked closely with the Bureau of Handicapped Children of the State Department of Public Instruction and the Public Assistance Division of the State Department of Public Welfare in several problems concerning programs under their jurisdiction.

The Wisconsin Hearing Conservation Program, operated through the Bureau of Handicapped Children, is reviewed annually by the Division. It is reported that 26 counties are currently participating in the rotating hearing testing program. In addition, Madison and five suburban communities in Milwaukee are included in the program. Fourteen cities have an annual hearing conservation clinic.

In the publicly-sponsored programs the children are screened at 500 and 4,000 cycles and must show an ability to hear each sound at the 25 decibel level. The Division believes that this portion of the program is producing satisfactory results.

The Division calls attention to the fact that there is need for more intensive follow-up on children whose hearing is determined to be defective. Repeat testing is frequently necessary and hearing aids should be provided in many instances. Parental and physician follow-up are essential to make the program a success.

Because of the limited number of otologists available to serve all areas of the state, the Bureau of Handicapped Children has encountered some problems in obtaining enough otologists to assist in operating the annual hearing testing program. It is felt that improved methods of scheduling the hearing clinics will ease the burden on the available otologists and efforts to this end will be made by the directors of the hearing conservation program.

Studies are under way in cooperation with the Committee on Industrial Health of the State Medical Society concerning the use of safety goggles in industry. A meeting is being arranged with representatives of the Committee and the Division plus representatives of the Society for the Prevention of Blindness and the Wisconsin Council of Safety.

Special efforts will be made in the coming year to obtain greater distribution and understanding of the Society's publication entitled, "Hearing Conservation Programs for Wisconsin Industries." These efforts will be directed particularly to members of the Wisconsin Council of Safety and the Visiting Nurses' Association. The Division re-emphasizes its earlier statement that audiometric testing by nurses and other personnel is approved providing these persons are adequately trained in the procedure. However, evaluation of the audiogram is a medical function to be performed by a physician.

As a result of recent discussions, the Division suggests that there may be an over-emphasis on visual and hearing testing in motor vehicle drive licensing procedures in Wisconsin. While not opposing present hearing and vision screening standards, the Division suggests that these testing procedures be placed in their proper perspective in relation to the number of accidents actually related to these causes. It has been learned that a small percentage of all accidents can be related to visual acuity or auditory defects. Driver attitude is believed to be a major cause of the so-called preventable accidents. In other words, it is suggested that vision and hearing screening produce a false sense of security for the driver unless he can be impressed that safe driving on modern highways is a challenging test in the complete coordination of all physical and emotional skills and attitudes.

Respectfully submitted,

DIVISION ON VISUAL AND HEARING DEFECTS

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Meyer Fox, M.D., Milwaukee
James Bolger, Jr., M.D., Waukesha
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Special Invitee:
John B. Hitz, M.D., Milwaukee, Section on Ophthalmology and Otolaryngology

REPORT OF DIVISION ON HANDICAPPED CHILDREN

H. A. SINCOCK, M. D.
Chairman

Orthopedic Programs

The orthopedic clinic programs of the Bureau of Handicapped Children have been the subject of continued review by the Division. Special attention has been directed to modifications which seem indicated on the basis of available orthopedic personnel in the area served. Traditionally, the clinics have been conducted upon the direct request and approval of the county medical society. There seems to be no reason to change this procedure. At the same time, in the 1957 and 1958 sessions of the House of Delegates recommendations were approved to provide that in areas where two or more qualified orthopedists are in practice, the clinics may be discontinued if such is the desire of the county medical society and if, in the opinion of the Bureau and the orthopedists in the area, both old and new patients can and will be adequately served on a direct referral basis.

On the basis of action by the Brown County Medical Society the clinics in that area have been discontinued. Other county medical societies which have requested clinics in the past are being contacted to ascertain their desires for continuation of the clinics. Orthopedists who have previously served these clinics are simultaneously being asked for their advice.

At the request of the Council, a study is being made of the current rules of the Bureau of Handicapped Children with reference to limitations requiring that patients receiving treatment through Bureau funds be served only by members of the American Board of Orthopedic Surgery. Inasmuch as rules now in force serve as the basis for an approved plan to secure federal funds, the subject will require considerable study and will be reported to the Commission on State Departments and to the Council at a later date.

Bicillin Program

Progress of the bicillin program continues to be reviewed by the Division. This program is conducted by the Bureau of Handicapped Children in cooperation with the Wisconsin Heart Association. It provides a mechanism for making bicillin available to patients at a reduced rate upon the request of the family physician. It is offered for cases in which long term care is indicated and where in the opinion of a physician the cost of medication would be a financial hardship to the family. Only about 300 patients are served by the program and to date there have been only a very few problems related to its mode of operation. Because some physicians have not fully understood how patients are certified for participation, it is suggested by the Division, approved by the Commission on State Departments, that information on the program will be provided to all physicians through the *Wisconsin Medical Journal.*

One slight modification of the program has been recommended and approved by the Commission on State Departments. In instances where the original order of bicillin has been exhausted and the family has failed to re-order, the local public nurse is notified by the Bureau of Handicapped Children. She will visit the family and request their cooperation. The nurse will contact the family physician prior to such a home call to ascertain if there are any reasons why re-order of the drug should not be made. The determination of continued medication rests entirely within the judgment of the family physician.

Other phases of the Bureau of Handicapped Children's programs are reported to the House through the Division on Visual and Hearing Defects.

Respectfully submitted,

DIVISION ON HANDICAPPED CHILDREN

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REPORT OF DIVISION ON REHABILITATION

R. W. BOYLE, M. D.
Chairman

Since the founding of the Division on Rehabilitation of the State Medical Society of Wisconsin, Commission on State Departments, recognition of the enormity of the field of medical rehabilitation is gradually taking place. This Division has been assisting the federal and state supported State Board of Vocational and Adult Education, Rehabilitation Division, to better carry out those duties assigned to it. Past reports have been published and *Wisconsin Medical Journal* articles and editorial remarks have been made relative to these activities. The understanding between the state's physicians and the work of the State Board of Vocational and

Adult Education, Rehabilitation Division, is becoming more cooperative. There is still a wide gap in the education of the practicing physician as to what role this state agency may play in helping him to better and more completely care for his patients.

To try to fill this gap, the State Medical Society has sponsored symposia, lectures and exhibits at the Annual State Convention. There have been local lectures and demonstrations sponsored by the Wisconsin Heart Association, county medical societies, the State Board of Vocational and Adult Education and Marquette University School of Medicine.

However, the hard core of such education must necessarily be the responsibility of the medical schools of the state and the teaching hospitals where medical school graduates can see rehabilitation going on in their clinical experience. The two state medical schools have such educational facilities and the hospitals of the larger cities also provide for some training and services.

Physician Responsibility

The present day philosophy is that every physician must undertake to understand that the comprehensive care of a patient includes his social, economic and vocational readjustment. It does little for a man's welfare to save his life but leave him unable to pursue some sort of adjusted living in his own environment. Only the physician is able to judge his (the patient's) mental and physical capacity to resume his place in society or under what conditions or restrictions he can return. Until this final adjustment is made, it remains the physician's responsibility. Facilities for such transitions are becoming increasingly available in this state, but they must be used wisely and under the physician's guidance until the final adjustment has been satisfactorily completed.

It has been said that 80% of all patients can be rehabilitated through their own physician. This is obvious and has been an integral part of medicine for centuries. If a foreign body is removed from the eye and proper precautions have been taken to prevent the loss of the eye, then the patient can return to his occupation and complete rehabilitation has been accomplished. It is only the 20% of patients who, due to complications, severely disabling injuries or diseases, must have, in addition to definitive care, the services of many professional and paramedical disciplines to effect their rehabilitation. It is these services which are costly but essential to restore man's dignity, faith and self reliance. When this is re-established the cost is relatively unimportant. This philosophy is the goal of future medical education.

Chronic Disability

It would be an omission not to mention the care and treatment of the chronically disabled and geriatric patients. In this instance, the physician cannot think in terms of social and economic independence. Yet this fast growing segment of our population must be rehabilitated to whatever degree of independence is possible. This might only be self care in a very protected environment, but even this maintains the dignity of the individual. The problem of chronic disability and geriatrics is the product of advances in medical science and cannot be dumped into the laps of laymen and politicians for solution. Medicine has contributed to the problem and therefore must continue the research which will bring about the proper solution. The present trend of turning this problem over to the state for solution is improper although state's aid might be required to help medicine toward a solution.

Respectfully submitted,

DIVISION ON REHABILITATION

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REPORT OF DIVISION ON CHEST DISEASES

H. A. ANDERSON, M. D.
Chairman

Since the Annual Meeting of May, 1958, the Division on Chest Diseases has concentrated largely on two programs directly related to the work of the Wisconsin State Board of Health: (1) expanded use of mobile units, and (2) study of tuberculosis and the use of sanitaria facilities.

Mobile Units

In previous reports of this Division it has been emphasized that in spite of new medications and improved surgery which have lessened mortality associated with tuberculosis, the morbidity rate in Wisconsin remains high. Improved methods of case finding have brought to light many new cases of tuberculosis, and have re-emphasized the need for an intensive and expanded case finding program.

A critical study of age groups re-affirms the opinion of the Division that for the lower age groups tuberculin testing is the best approach to case find-

ing. For older age groups and selected studies the x-ray program of the mobile units remains the most effective method of mass screening for tuberculosis.

Recognizing the large number of cases of potential heart trouble or suspected cancer revealed by the mass x-ray screening technique, the Division has viewed with approval the expanded use of mobile units to screen for chest conditions other than those directly associated with tuberculosis. The findings to date have been impressive. It is felt that with the cooperation of physicians through follow-up studies many persons with suspected heart trouble or possible cancer of the lung can be brought under medical supervision at a time when therapy can be of long-time value to the patient.

During this past year the State Board of Health has conducted a pilot study, with a blood pressure machine being used as a rough screening device in the mobile unit, to reveal suspected and unrecognized hypertension. This study has been conducted only in areas where the local county medical society has approved it or requested it. The results of this pilot study will be transmitted to the House with recommendations when sufficient data has been collected to permit significant evaluation.

Hospital Admission X-Rays

The Division on Chest Diseases re-affirms its approval of routine x-rays on all hospital admissions and an appropriate patient charge for such service. The programs conducted to date have revealed a number of cases of unsuspected tuberculosis. The public health aspects and the protection afforded hospital patients and personnel hardly need repeating. If properly established, the cost is not burdensome to an individual patient, and the beneficial aspects seem obvious to the Division.

Radiation Hazards

In the last report of this Division attention was directed to radiation hazards in relation to x-ray exposure. There continues to be some misunderstanding on this subject both among physicians and non-medical persons. The Division wishes to reiterate that with proper equipment and proper protection there is no significant danger to the patient or the person giving the chest x-ray. Question has been raised as to the effect of repeated chest x-rays on the reproductive organs. While it is obvious that often repeated or promiscuous use of x-ray in pelvic studies or even abdominal examinations may present problems of consequence, the usual x-ray employed for the detection of tuberculosis or related chest conditions offers no hazard of significance to the patient or the operator. It is important that physicians understand the problem of radiation hazards and inform the public so that there will be no resistance to screening programs where x-ray exposure is slight and of no significant danger to the public.

Problems of County Sanatoria

The problems of county sanatoria faced with decreased occupancy by persons being treated for tuberculosis are well known to members of the Division on Chest Diseases. The economic aspects of the problem are not to be minimized, but the major concern of the Division is one of proper medical care for the patients being served. Confronted with the problem of decreased bed occupancy five counties have arranged for dual use of such facilities for the aged and the tuberculous. Several other counties are considering similar dual usage.

Criteria for the dual use of county sanatoria were approved by the House of Delegates in 1956. At the same time, attention was directed to the desirability of regional programing so as to maintain a full load of tuberculosis patients in a single institution. Where this was not practical it was suggested that facilities be used in such a way so that patients served will be primarily medical in character and not merely persons in need of domiciliary care. The Division was concerned that if functions are to be mixed so there is a minimum of medical care provided it will be increasingly difficult to hold physicians as medical directors of county tuberculosis programs. This would in turn result in serious setbacks of the overall state TB program.

The Division continues to be deeply concerned with this matter. By the time of the May meeting of the House of Delegates it hopes to present a supplementary report with recommendations.

Respectfully submitted,

DIVISION ON CHEST DISEASES

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George R. Barry, M.D., Monroe

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Special Invitee:

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REPORT OF DIVISION ON MATERNAL AND CHILD WELFARE

G. S. KILKENNY, M. D.
Chairman

Maternal Mortality

The interpretive phases of the Maternal Mortality Survey have been continued during the past year. Four half-way conferences of physicians and hospital personnel were held in March, 1958. Three similar meetings were held in January, 1959. A total of 882 physicians, nurses, interns and medical students attended these instructional programs.

Four of these programs were tape recorded. The tapes are now available to hospital staffs and county medical societies upon request.

Prenatal Facts Widely Used

The use of "Prenatal Facts" forms has become increasingly popular. Nearly 200 physicians and clinic groups are ordering these forms regularly. "Prenatal Facts" are designed to provide the hospital with important prenatal information to anticipate special problems of delivery and for use in event the attending physician is not available at the time the patient is admitted to the hospital.

Paranatal Problems to Receive Emphasis

Wide acceptance of the Maternal Mortality Institutes has prompted the Division to organize similar teaching programs for physicians and hospital personnel in areas of paranatal care, including special problems of prematurity. This new teaching program will cover problems of labor, infant resuscitation, special problems in the first day of life, and a topic entitled "Prematures Can Be Healthy, Too." A team of two pediatricians, an obstetrician and an anesthesiologist will provide the instruction. The programs are tentatively scheduled for late summer or early fall in the eastern part of the state.

Assistance in Adoption Problems

Adoption procedures in Wisconsin have received special study by the Division. Placement of a baby by a physician, with or without exchange of monies, is illegal. The legal aspects of child placement and adoptions are clearly outlined in the *Wisconsin Medical Journal*, January 1959, page 35.

The physician, however, has several direct and indirect responsibilities in adoption. In addition to maternity and medical care for the natural mother and her child, the physician is often called upon for advice and help to a couple seeking to adopt the child. He is frequently asked to provide information as to their good health and life expectancy. In most cases an adequate fertility assessment is required.

The Division has, after detailed study and analysis, recommended that all adoption agencies in Wisconsin secure a medical advisor for the review of medical information requested of adoptive parents. In addition, the Division has recommended the type of report form which it believes desirable for securing information on fertility studies.

Poison Control

Promotion of poison control projects has been correlated with efforts of the Wisconsin Chapter of the American Academy of Pediatrics. Physicians and hospitals have been alerted to emergency procedures. All have been notified that detailed information on poisons can be secured on a 24-hour-a-day basis at Children's Hospital, Milwaukee, and University Hospitals, Madison. Encouragement has been given to the establishment of additional poison emergency facilities and informed personnel in specified local hospitals.

Immunization

In cooperation with the Division on School Health, studies have been made of the immunization levels of Wisconsin residents. Reports indicate a relatively small percentage of children receiving adequate immunization protection during the pre-school years (0–4) when it is most needed.

A guide for county medical societies is being prepared to assist in the effective handling of this important health problem and parental responsibility. Parental education is promoted through special notices sent by the State Board of Health at the time birth certificates are mailed to parents. These notices emphasize the necessity of immunization, set forth a schedule of immunizations and encourage consultation with the family physician.

Recommendations

The Division recommends that:

1. Physicians establish firm routines for immunization of the newborn under their care with a view to completing the DPT and polio series on all children prior to their admission to school. In addition, physicians are urged to take an active role in immunization education programs planned in cooperation with interested lay groups.
2. Physicians provide adoption agencies with appropriate medical information concerning adoptive parents and that they send such information to a physician consultant of the agency rather than directly to the agency.

3. Medical staffs of hospitals establish procedures for proper handling of poison cases, and that all physicians and hospital personnel be alerted to the fact that specific information for the care of poison victims can be secured at all hours, day or night, through Children's Hospital, Milwaukee, or University Hospitals, Madison.

Respectfully submitted,

DIVISION ON MATERNAL AND CHILD WELFARE

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REPORT ON IMMUNIZATION PRACTICES IN WISCONSIN

April 10, 1959
by
Division on School Health
and
Division on Maternal and Child Welfare

Wisconsin's health record with regard to diphtheria, whooping cough, smallpox, polio and tetanus has been extremely good, largely as a result of effective immunization.

There is, however, growing concern that the level of immunization against these conditions is not being maintained at a point consistent with the public health and safety. Statistical data are not available to fully corroborate such fears, but there are "indicators" pointing to substantial gaps in the ideal of complete immunization coverage.

Immunization in Wisconsin is being accomplished by a combination of service through physicians' offices and public clinics. The degree to which either or both methods are used varies widely from county to county. The choice is a local matter, as it basically should be; yet there is a definite trend among both medical and non-medical groups to place increasing emphasis on immunization as part of the family physician's regular care of the individual.

Ideally, all children should complete their immunizations against diphtheria, whooping cough, tetanus, smallpox and polio before their first birthday. Thereafter, booster shots should continue at regular intervals, even for adults.

Because of the extreme importance of the initial immunization series being completed during the first year of life, both to provide basic protection and firmly establish family immunization patterns, this report will deal primarily with immunization of children of pre-school and school ages.

Immunization Levels in Wisconsin Today

Very little specific information is available concerning immunization levels among Wisconsin children. It is safe to assume that no area has 100 per cent coverage. This will very likely always be true. However, if the number of unprotected persons is allowed to increase considerably at any time, an epidemic may easily occur.

Two studies reported by the State Board of Health give some indication of the problem.

A 1953 study in Jefferson County indicated approximately 36 per cent of the children receiving DPT immunizations within their first year of life, another 25 per cent receiving the immunizations when they reached the ages of 1–4, nearly 9 per cent received the immunizations between ages 5–9, less than one-half per cent received them between the ages of 10–14 years and 30 per cent did not receive them at all.

The same study revealed 6 per cent of the children between 0–14 years receiving smallpox vaccination within their first year of life, 23 per cent received it between the ages of 1–4 years, 14 per cent between the ages of 5–9, 1 per cent between ages 10–14, and 56 per cent received no smallpox vaccination.

The Jefferson County study showed that among those who had received DPT immunizations more than 90 per cent in the age group 0–4 received them from private physicians. In the age group 5–14, about 60 per cent received the immunizations from private physicians and about 30 per cent from public clinics.

A more recent study (1957) by the State Board of Health surveyed public clinic services in the area outside Milwaukee County. This area contained a total of 1,162,000 children between the ages of 0–19. Of these, 352,000 were between the ages 0–4.

According to the study, public clinics in 1957 provided smallpox immunizations to 5.3 per cent of the children aged 0–19. A total of 6.6 per cent of this age group received DPT immunizations and 11 per cent received polio injections.

In the all-important age group 0–4 years, only 6 per cent attended public clinics for DPT immunizations and only about 5 per cent attended for polio immunizations.

It is clear that, regardless of the reasons, the public clinics serve only a very small percentage of the population requiring immunization.

Other reports, such as those from the Pediatrics Department of the University of Wisconsin Medical School, tend to confirm the belief that as many as 50 per cent of the pre-school and school age children

in many areas of the state may have obtained no immunization of any type. On the contrary, a report from the County of Sheboygan, where all immunizations are conducted through the offices of individual practitioners, indicates basic DPT protection among 70 per cent of the 0–19 year-olds and about 56 per cent with smallpox protection.

Furthermore, there is rather unanimous agreement among practicing physicians that failure to obtain basic tetanus toxoid immunization is proving extremely costly in terms of time and wages lost and Workmen's Compensation payments as a result of illness from serum reaction to tetanus antitoxin. With the truly tremendous number of occupational and non-occupational injuries in each year, basic tetanus protection is an absolute must for public safety. Yet, for the most part, only those who served in the armed forces since 1940, and young people who have had their DPT injections, have acquired the necessary sensitivity to respond quickly to an emergency injection. It seems safe to say that the cost of man-hours lost because of serum reaction from tetanus antitoxin after injury far exceeds the cost of all the tetanus toxoid programs of a preventive nature. There is dire need for adults as well as children to obtain and maintain an adequate tetanus toxoid sensitivity.

Reasons for Gaps in Immunization Levels

A great many factors affect the utilization of immunization procedures by the public. Some of those most prominently mentioned in current discussions were:

. . . . Absence of epidemic or serious outbreak of disease has caused the public to believe that the diseases are no longer "important".

. . . . Either through ignorance or apathy, or both, parents are not exercising sufficient responsibility for protecting themselves and their children.

. . . . Public failure to appreciate the importance of immunization in the first year of life plus regular boosters thereafter.

. . . . Cost factor . . . in some instances the cost of a baby sitter plus an office call raises expense to the point of causing hesitation and delay.

. . . . Poorly planned promotional efforts by some communities.

. . . . Physician failure to impress patients as to the need for immunization . . . . lack of deliberate follow-up with mothers of the newborn.

Obviously, no single factor can be selected as the major cause for gaps in the over-all immunization status. However, two areas suggest themselves as offering the opportunity for bringing to the people substantial long-range benefit: (1) Public education and community support and (2) Exercise of physician responsibility.

With these points in mind, the Division on School Health and the Division on Maternal and Child Welfare join in presenting their recommendations as a guide to physicians, county medical societies and community organizations.

GUIDE TO IMMUNIZATION PLANNING

Recommended Procedures for Routine Immunizations

The following procedures, based on the recommendations of the American Academy of Pediatrics, approved by the Wisconsin State Board of Health and endorsed by the Society's Division on School Health and Division on Maternal and Child Welfare, are recommended for routine immunization of all children and adults:

(NOTE: these suggestions are applicable only for healthy children. There are certain contraindications to immunization procedures. Thus, it is important that the advice of the child's physician be sought and followed.)

DPT Immunizations

PRODUCTS USED

DPT—(alum or aluminum phosphate precipitated or aluminum hydroxide adsorbed diphtheria plus tetanus toxoids and H. pertussis vaccine.)

DT—"standard type" (containing 5 Lf diphtheria and tetanus toxoid units each per 0.5 cc.)

DT—"adult type" (containing 1 to 2 Lf diphtheria toxoid units and 5 Lf tetanus toxoid units each per 0.5 cc.)

INITIAL SERIES:

Children up to the age of 6 years:

It is recommended that the first dose be given at the age of 1 or 2 months. Children up to the age of 6 years, who start their immunization later, follow the same schedule.

ANTIGEN USED: Standard DPT.

SCHEDULE: Three injections, 0.5 cc. each, one month apart.

Children between the ages of 6 and 10 years:

ANTIGEN USED: DT "standard type" or standard DPT at discretion of physician.

SCHEDULE: Two injections, 0.5 cc. each, one month apart.

Note: Pertussis vaccine is omitted because it may cause severe reaction in children after the age of 5 years.

Children needing special protection will follow the recommendation of their family physician.

Children older than 10 years:

ANTIGEN USED: DT "adult type."

SCHEDULE: Two injections, 0.5 cc. per dose, one month apart.

DPT "BOOSTER" INJECTIONS:

Children up to the age of 6 years:
The first booster consists of an injection of 0.5 cc. of DPT one year after the initial series is finished. A second booster (0.5 cc. DPT) is recommended 2 years after this injection.

Children between the ages of 6 and 10 years:
Boosters consist of an injection of 0.1 cc., I.M. of DT "standard type" to be given at 3 to 4 year intervals.

Children older than 10 years:
0.5 cc. of DT "adult type" to be given at 3 to 4 year intervals.

Note: Pertussis "boosters" are omitted after 6 years of age for reasons previously stated.

Polio Vaccinations

Recommend starting the immunization series at the age of 2 or 3 months. The basic series consists of three 1 cc. injections of vaccine. Injections may be given the same day as DPT or DT, but a different location should be used. Give the second dose after one month and the third injection should be given 6 to 8 months later. Children who started their polio immunizations at a later age, and adults, should receive the same dose and time schedule.

Note: A new type of injection containing DPT and polio antigens in one solution is being developed. When used in such single solution, the site of injection will naturally be single.

Smallpox Vaccinations

The recommended age for primary vaccination for smallpox is between 6 to 8 months. Children in whom DPT and polio immunizations are started at a later age, may receive their smallpox vaccination any time in the interval between the other injections. Children should be vaccinated against smallpox during the first year of life. Encephalitic complications are rare in this age.

Contraindications to Immunizations

1. *Upper respiratory or other infections.* (A delay as long as 4 to 6 months is permissible between any of the three injections of the series.)
2. *Infants with CNS disease with a tendency to have convulsions* should not start their injections until after the age of 12 months.
3. *Infants with eczema or other dermatitis* shall not be vaccinated against smallpox.

   Siblings of infants with eczema or dermatitis shall not be vaccinated for smallpox unless the infant with eczema or dermatitis can be separated for ten days from the child vaccinated. *Separation means to be in different homes.* They cannot stay in different rooms of the same household. This is for the protection of the child with the skin lesion.
4. Parents should be advised to consult their family doctors about the advisability for routine immunizations in times of poliomyelitis prevalence in the community.

Parental Responsibility

Immunization is first and foremost the responsibility of parents toward themselves, their children and the community.

The public should make use of all vaccines available for the control of disease. If the public health is to be properly protected . . . if unnecessary disease, distress and financial loss are to be avoided . . . *all* citizens must take advantage of immunization protection for the following conditions:

Diphtheria occurs at any age . . . it is important that all persons be immunized to prevent its return to Wisconsin as a deadly disease.

Whooping Cough is common and exceedingly dangerous among infants and pre-school children. It may cause serious complications.

Tetanus (lockjaw) results from contaminated injury, especially infected wounds.

Smallpox protection is needed by all ages . . . any serious letup in immunization may open the door to epidemic.

Polio deaths and disabilities can be prevented with vaccine. All ages up to 40 need it.

Typhoid and virus flu vaccines are to be used when physicians and public health officials believe them necessary . . . especially in time of epidemic and disaster.

It should be noted that the State Board of Health informs prospective mothers of the importance of immunization through its prenatal letter service and other avenues of communication. A special bulletin concerning immunizations is included with the birth certificate which is sent to the parents by the State Board of Health, usually about three months after birth.

Physician Responsibility

Immunization is a routine part of family medical care provided by the physician.

It is a basic responsibility of the practicing physician to aggressively urge DPT, smallpox and polio immunizations for his patients, especially during the first year of life.

This includes the *duty* of providing an immunization reminder to the parents of a newborn child three months after birth and as often thereafter as is desirable according to the "Recommended Procedures for Immunization."

This may be accomplished in a variety of ways so long as it is done ethically and in good taste. Some suggestions:

A. As part of routine, well-baby checkups, immunization scheduling should become a regular part of over-all pediatric care.

B. Post card, letter or telephone call reminders to parents of patients. This technique is recognized as necessary and is endorsed by the American Medical Association.

C. Set aside an hour or day each week or month which patients may regard as "immunization time."

D. Periodically distribute to patients, the State Board of Health, AMA or other literature concerning immunization.

E. Post reminder notices in office reception rooms.

F. Develop immunization scheduling as a part of over-all routine well-baby care.

Medical Society Responsibility

The county medical society, as the organization chiefly responsible for the scientific excellence of the medical community and the quality of medical care provided the people within its area, has a basic duty to assure availability of immunization at reasonable cost for all citizens.

It is recommended that each county medical society:

A. Do its utmost to promote routine use of immunization procedures for all citizens and particularly among the newborn in the first year of life.

B. Encourage physicians to provide immunization service as part of their practice.

C. Carry out its public health responsibility by bringing immunization within the reach of every citizen. In accomplishing this it is important that the medical profession give full assurance that immunizations will be provided to all persons regardless of financial circumstances. Where the patient visits the physician solely for the purpose of immunization, it is recommended that charges for immunization be established in direct relationship to the actual cost of material plus a nominal charge to reflect the service and responsibility involved.

Each county medical society should seek to establish such immunization programs as best suit the needs of the community. This may be accomplished through private physicians' offices, public clinics, or both.

Since immunization is a routine part of the average physician's practice, the decision to augment their services with public clinics depends largely upon an evaluation of the current immunization level. The effectiveness of public clinics or private physician programs in reaching the largest number of people will depend upon the availability of physicians, transportation problems, and community customs and cooperation.

Advantages of private physician's office programs are:

A. Patients can be examined as "whole beings" and immunizing procedures become a part of total medical care.

B. Basic immunization will be given within the first year of life. This is done best as part of routine infant care in the doctor's office. Public clinics reach almost no children under one year of age.

C. Various health conditions contra-indicate immunization. These are best evaluated by the physician in his own office.

D. Occasional reactions can be better prevented or controlled.

E. A complete patient immunization record in the hands of the family physician is important for later years.

Advantages of public clinic programs:

A. A means of supplementing physician office programs . . . and picking up "stragglers."

B. Readily adaptable to publicity.

Regardless of whether one of these methods is used exclusively or they are combined in some fashion, full community support is required for success. This means a continuous cooperative effort of physicians, parents, teachers, civic leaders and all interested non-medical groups. All avenues of public information should be used—radio, newspaper, television, bulletins, public meetings, etc.

County medical societies are urged to take initiative and to cooperate in community planning to bring about public understanding and acceptance of the needs for immunization.

Community Planning

Proper advance planning by all interested parties will result in better relations between the medical profession and other groups and, of course, more adequate immunization coverage.

The late summer and early fall may bring the subject of immunization clinics into public focus. It is important that parents and the general public understand that the ideal time for initial immunization is *long before entrance into school.* With an adequate private practice program only boosters should be needed at school age.

Public understanding and improved relationship between all groups will be greatly enhanced by developing the immunization program through joint action of the medical profession, local officials, school administrators, and interested citizens.

. . . . In areas where well-established immunization pattern is functioning effectively, it is nevertheless advisable to periodically meet to review the results and re-educate responsible officials and the general public to the necessity of immunization procedures.

. . . . Whenever a major change is contemplated in an existing immunization pattern or program, conferences between all interested parties is important for public understanding.

It is recommended that each county medical society take the initiative in working with appropriate groups on the type of program best suited to the area. The medical society's school health committee is a logical group to handle such activity. If no such committee is available, it is suggested that the county society call a conference of medical society representatives and such persons as the county nurse, county superintendent of schools, a local school superintendent, the local health officer and representatives of local public health councils, PTA's, service clubs and similar groups.

These representatives should meet to determine whether the services of individual practitioners need be augmented by public clinics, and if so, to what extent. When that decision has been made, all parties should direct their efforts toward a thorough job of promoting immunization.

Publicity and Promotion:

To be effective, immunization promotion must reach into every part of the community. The following are a few suggestions:

. . . . Give publicity to the reasons why immunizations are necessary.

. . . . Indicate what immunizations are recommended for each age group.

. . . . Provide assurance that physicians will give immunizations to all . . . . that no one will be denied immunization or be unreasonably charged for immunization.

. . . . Designate a certain time as "child protection day or week." If the approach is through the physicians' offices the public should be informed of arrangements. If this is done through the use of public clinics the time, place and hour should be emphasized.

. . . . Local service clubs or other organizations may be anxious to promote immunizations as an annual project.

. . . . Sponsored ads in local papers may be arranged either through the medical society or public spirited citizens.

. . . . Every reasonable publicity method should be used . . . . newspaper stories, radio and television news and talks, posters, charts, bulletins, meeting announcements, speeches and the like. Many public spirited citizens will join in aiding a truly public service project.

Public acceptance and understanding of an immunization program should be based upon full and proper information widely disseminated.

RECOMMENDATIONS
of the
Division on School Health
and
Division on Maternal and Child Welfare

April 10, 1959

A. That the House of Delegates authorize the preparation and distribution of "immunization reminder cards" to all physicians upon request and at the expense of the State Medical Society as a public service.

B. That the State Medical Society, through its various communications to members, publicize one or more effective methods of setting up a simplified scheduling system in a physician's office to facilitate contact with patients who are periodically due for immunizations.

C. That the Council on Scientific Work consider including the subject of immunization and related problems in its annual meeting, circuit teaching and county society speakers programs.

D. That the Committee on Medical Education and Hospitals discuss immunization training and experience for medical students, interns and residents with the Deans of the two medical schools in Wisconsin with a view to assuring a broader experience before entering practice.

E. That all new members of the State Medical Society receive copies of the School Board of Health Guide for Immunization Procedures.

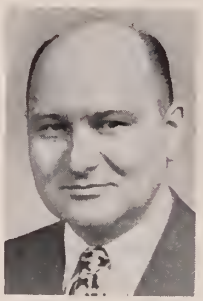
F. That editorials and scientific articles dealing with immunization in "brief" form be prepared and published periodically in the *Wisconsin Medical Journal.*

G. That members of the Divisions on School Health and Maternal and Child Welfare serve as "consultants" to medical societies requesting their services in regard to local problems.

See opposite page 400
for
IMMUNIZATION PROCEDURES

Tear out and
retain for reference
Additional Copies Available
from SMS Office

REPORT OF THE COMMISSION ON MEDICAL CARE PLANS



E. M. DESSLOCH, M. D.
Chairman

A Report to the Physicians of Wisconsin

This is largely a statistical and financial accounting of the insurance activities of the State Medical Society of Wisconsin during 1958. Such an accounting is essential if the Society is to fulfill its obligation to members who support these programs and to the subscribers whose funds have been placed in our stewardship.

Although this report deals with statistics, the Commission emphasizes that it never looks upon either patients or physicians as statistics. This Commission has sought always to design and operate the Society's insurance efforts with the personal relationship between physician and patient as the keystone.

Nowhere is this better exemplified than in the Special Service (no-fee-schedule) Plan of WPS–Blue Shield, a plan regarded nationwide as a pioneering achievement.

More recently, the Century Plan for citizens over age 65 demonstrates again the Commission's concern for the human factors which are inevitably a part of the economics of health care.

These are days quite reminiscent of the late 1930's when the State Medical Society began the voluntary prepayment movement in Wisconsin. Now, as then, the medical profession faces a great struggle for re-organization of medical services in which there is real danger that high quality, individual and personalized patient care may be subjugated by corporate power. Now, as then, the future must be met by bold, common sense action of the medical profession, acting in the highest form of public interest.

This past year has been both difficult and rewarding. Perhaps no one can accurately estimate the WPS–Blue Shield as an instrument of the profession for service to the public. This effort was certainly hours and days spent to preserve and improve one of service "above and beyond the call of duty" by commissioners, councilors, officers and innumerable county society officers and members. The Commission notes it as something more than to be taken for granted.

At the same time, the Commission wishes to make some brief but important remarks concerning the administrative aspects of WPS–Blue Shield operations.

WPS Staff Organization

In order to provide relief at the desk of the Secretary, and to enable him to devote his principal energies to operations of the Society which are other than "insurance" in nature, arrangements were made for study of the WPS–Blue Shield organization by an insurance management consultant. This study and its implementation has, for the most part, been completed.

Generally speaking, the staff operating organization of WPS–Blue Shield is now along traditional "insurance" lines. The responsibilities and duties of key executives and other supervisory personnel have been redefined and will be subject to review and revision.

The delegation of authority and accountability for results has been more precisely pinpointed.

The services of the insurance management consultant will continue to be used in the coordination of insurance operations, subject to review by and approval of the Commission.

Consultants

It has long been the practice of WPS–Blue Shield to utilize consulting services in the accounting, actuarial, and legal fields.

With expansion of insurance operations into hospital coverage, demands on the services of such consultants have increased.

In addition, an insurance management consultant was engaged during the past year to assist key members of the staff in selected technical and management areas.

The independent status of such consultants enables the Commission on Medical Care Plans and the WPS–Blue Shield staff to secure the benefit of maximum objectivity in their approach to problems in the fields of their respective specialties. At the same time, the cost of these services is less than would be the case if experts of comparable stature in each of those fields were added to the staff as full-time employees.

Growth

Evidence of "growth" in an "insurance" type of operation depends largely on the means of its measurement.

While a reduction in the number of subscribers would appear on the one hand to indicate retrogression, a substantial increase in "premium income" on the other would lead to an opposite but not contradictory conclusion.

As to WPS–Blue Shield, the understandable loss in 1958 of subscribers for whom surgical–medical coverages had previously been provided was more than offset, premium-wise, by the sale of hospital coverage to both "old" and "new" subscribers.

In terms of satisfying a social need, our objective continues to be that of making the services of WPS–Blue Shield available to the largest possible segment of the public in the areas in which it operates. Our overriding aspiration is to be not necessarily the biggest, but the best. Both long and short range plans are approached with those goals in mind.

—E. M. Dessloch, M.D., *Chairman*

Commission on Medical Care Plans

WPS–BLUE SHIELD

Financial Report

The accompanying financial statements reflect the first year of operation by Wisconsin Physicians Service–Blue Shield in which it performed all of its own administrative functions.

Significantly, in spite of unusual competitive factors and the necessity of expense related to transfer of functions, WPS–Blue Shield remains financially solid. In relation to total premium income of almost $6,000,000, a net loss in 1958 of about $91,000 is indeed minimal.

Significant, too, is the fact that in 1958 the net administrative expenses were 15.43% of total earned premium income as compared with 15.24% in 1957. It is an objective of the Commission in 1959 to reduce administrative expense to less than 15%.

The total excess of 1958 expenditures over income was $90,825.80. Of this amount there were special non-recurring expenditures of $30,286.23. There should be no similar expenses in 1959, since they represented services supplied in January 1958 by the former agent plus special costs connected with termination of the prior contract and development by WPS of its own administrative functions.

The balance sheet shows a total decrease in reserves during 1958 of $157,456.22. A major portion of this decrease was the effect of fluctuations in the market value of government securities. Market value as compared with book value was $66,072.05 less at the end of 1958 than on December 31, 1957. It should be pointed out that this is a matter over which WPS–Blue Shield has no control, and that such securities might fluctuate in the opposite direction during the coming year. This amount, however, plus the $90,825.80 referred to above, plus minor post-audit adjustments of $558.37, accounts for the total decrease in reserves in 1958.

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

COMPARATIVE BALANCE SHEET
December 31, 1957 and 1958

	12-31-58	12-31-57
ASSETS		
Cash on Hand and in Banks	$ 484,612.94	$ 404,440.41
Due from Agents	$ 7,157.09	$ 165,634.22
Refunds Receivable—Net	1,188.79	819.00
Premiums Receivable	166,552.37	
Due from Medicare—Advance	60,000.00	60,000.00
Due from Medicare—Current	57,078.91	30,206.34
Other Accounts Receivable	33,625.40	1,248.17
Total Receivables	$ 325,602.56	$ 257,907.73
U. S. Government Securities—Book Value	$2,823,768.32	$2,469,335.27
Less: Excess of Book Value over Market Value	77,240.32	11,168.27
Securities at Market Value	$2,746,528.00	$2,458,167.00
Mortgage Loans	325,000.00	276,000.00
Securities—Other	10,075.00	
Land and Buildings—Net	24,539.37	25,405.62
Total Investments	$3,106,142.37	$2,759,572.62
Leasehold Improvements—Net	$ 21,500.00	$ 22,500.00
Office Furniture and Fixtures—Net	77,676 67	65,825.07
Autos—Net	7,230.07	6,586.92
Total Fixed Assets	$ 106,406.74	$ 94,911.99
Accrued Interest Income	$ 12,871.09	$ 14,089.99
Deferred Charges	20,066.57	7,647.24
Total Assets	$4,055,702.27	$3,538,569.98
LIABILITIES AND RESERVES		
Accounts Payable	$ 34,032.35	$ 38,672.49
Merit Rating Credits Payable	13,845.54	12,650.43
Applicants' Premium Deposits	6,918.82	1,399.74
Provision for Incurred Claims Unpaid	979,000.00	717,700.00
Old Outstanding Checks	6,629.50	5,542.50
Unearned Premiums	841,748.96	433,155.33
Other Deferred Income	2,933.83	1,400.00
Total Liabilities	$1,885,109.00	$1,210,520.49
Reserves—Maternity Benefits	$ 258,400.00	$ 264,400.00
Disaster Benefits	550,000.00	509,379.00
Major Illness Expense		100,000.00
Unforeseen Contingencies	115,983.44	329,342.24
Administrative	1,000,000.00	900,985.24
Investment	246,209.83	223,943.01
Total Reserves	$2,170,593.27	$2,328,049.49
Total Liabilities and Reserves	$4,055,702.27	$3,538,569.98

COMING

NEXT MONTH

Transactions of 1959

Regular Session

House of Delegates

State Medical Society

WISCONSIN PHYSICIANS SERVICE

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES
Years Ended December 31, 1958 and 1957

	Current Year Percentage	1958	1957	Increase or (Decrease)
EARNED PREMIUM INCOME	100.00	$5,817,805.34	$5,309,753.78	$508,051.56
Less: Benefits Incurred	87.12	5,068,681.46	4,428,840.57	639,840.89
Available for Expenses and Reserves	12.88	$ 749,123.88	$ 880,913.21	($131,789.33)
ADMINISTRATIVE EXPENSES				
Agents' Expenses	.34	$ 20,007.60	$ 374,985.15	($354,977.55)
Salaries	8.69	505,784.74	236,952.00	268,832.74
Payroll Taxes	.26	14,902.81	6,585.63	8,317.18
Employees' Group Insurance	.28	16,617.75	7,087.77	9,529.98
Retirement Plan Contributions	.14	8,112.43	4,911.12	3,201.31
Actuarial Services	.10	6,116.40	4,310.84	1,805.56
Auditing Services	.22	12,844.56	8,224.10	4,620.46
Legal Services	.34	19,870.51	15,166.22	4,704.29
Conference Expense	.27	15,547 36	16,454.39	(907.03)
Travel Expense	.84	48,599.50	20,462.04	28,137.46
Association Dues	.17	10,088.30	10,685.72	(597.42)
Promotion	.25	14,387.65	6,448.54	7,939.11
Depreciation	.25	14,595.09	5,682.43	8,912.66
Amortization of Leaseholds	.02	1,000 00	1,000.00	----------
Insurance	.03	1,893.38	2,065.39	(172.01)
Office Supplies and Expense	.19	10,816.13	7,955.44	2,860.69
Postage	.44	25,714.42	9,809.75	15,904.67
Printing and Forms	.67	38,733 21	15,736.31	22,996.90
Rent—Office	1 32	76,621.22	58,856.80	17,764.42
Rental—IBM Equipment	.49	28,272.65	14,004.57	14,268 08
Telephone and Telegraph	.19	10,791.97	5,960.91	4,831.06
Other Administrative Expenses	.40	23,320 42	5,627.95	17,692.47
Administrative Income and Expenses Reclassified	(.46)	(26,635.78)	(32,954.19)	6,318.41
Total Administrative Expenses	15.44	$ 898,002.32	$ 806,018.88	$ 91,983.44
Net Operating Income	(2.56)	($ 148,878.44)	$ 74,894.33	($223,772.77)
Investment Income	1.52	88,338.87	73,578.69	14,760.18
Total	(1.04)	($ 60,539.57)	$ 148,473 02	($209,012.59)
SPECIAL EXPENDITURES (Non-recurring)				
Northwestern Wisconsin Experiment	--------	$----------	$ 8,437.43	($ 8,437.43)
Mobile Unit	--------	----------	12,469.12	(12,469.12)
Grants and Appropriations	----------	----------	5,000.00	(5,000.00)
Agents' Expense—A. H. S., Inc.	.25	14,525.69	----------	14,525.69
Development Expense	.01	518.67	48,631.50	(48,112.83)
Termination Expense	.26	15,241.87	32,819.54	($ 17,577.67)
Total	.52	$ 30,286.23	$ 107,357.59	($ 77,071.36)
Available for Reserves	(1.56)	($ 90,825.80)	$ 41,115.43	($131,941.23)

Claims Report

On the claims side of WPS–Blue Shield the volume continues to grow. In 1958 the claims department processed a total of 102,197 cases involving 132,988 procedures. The volume of claim payments for 1958 total $4,381,693 as compared to $4,223,932 in 1957.

For comparative purposes, the following claims figures are shown:

Year	*Cases Numbered*	*Dollar Value of Cases*	*Number of Procedures*
1957	103,469	$4,223,932	128,632
1958	102,197	4,381,693	132,988

The Special Service contract is developing throughout the state with more than 500 groups involving coverage for nearly 60,000 persons. The very nature of the Special Service contract requires a close relationship between the group which purchases the coverage, the county medical society of the area in which the coverage is in effect and the home office of WPS–Blue Shield. Since payments under the plan are made according to the "customary, usual and reasonable" charges of the physician it follows that the creation of insurance advisory committees by the county medical societies is important for the proper operation of the plan. The cooperation of physicians throughout the state has been most noteworthy.

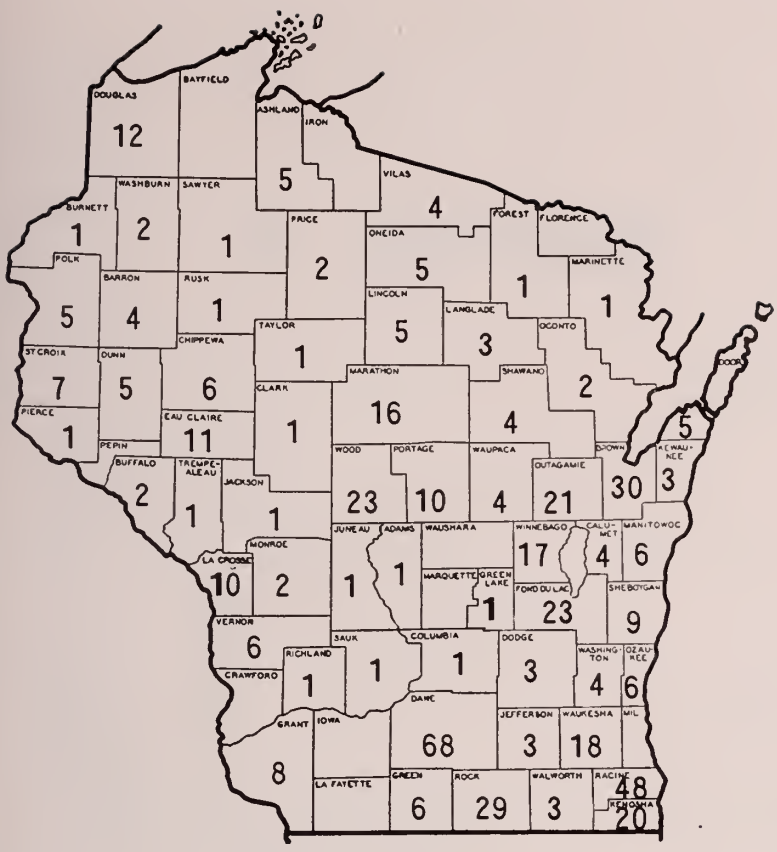
At the present time 24 county medical societies have established advisory committees to handle the administration of the Special Service contract. These county societies are:

Barron–Washburn–Sawyer–Burnett
Brown
Dane
Dodge
Douglas
Eau Claire
Fond du Lac
Forest
Green
Kenosha
La Crosse
Lincoln
Manitowoc
Oneida–Vilas
Pierce–St. Croix
Portage
Racine
Rock
Sauk
Shawano
Sheboygan
Vernon
Waukesha
Wood

The Claims Committee of the Commission on Medical Care Plans, composed of six members of the Commission, meets regularly to handle unusual claims. The Medical Advisor, Robert C. Parkin, M.D., Madison, devotes about one day each week to advising with the staff of the claims department on matters relating to "A" and "B" schedule cases. Special Service contract cases are referred to county medical society committees for advice and guidance.

Sales Report

The Special Service or "no-fee-schedule" contract was originated in 1955 and offered on a limited, experimental basis throughout 1956. During the experimental period it was demonstrated that there was a reasonable public demand for this program which paid benefits in accordance with the reasonable charges of physicians rather than on the traditional fee schedule basis. In addition, it was demonstrated that this type of program could be offered to groups at a reasonable premium. Consequently,



LOCATION OF SPECIAL SERVICE GROUPS
December 31, 1958

in the spring of 1957 the program was made available to eligible groups throughout Wisconsin (except Milwaukee County).

During the first half of 1958 the WPS–Blue Shield sales department spent the majority of its time presenting this new program to WPS groups. Their efforts were successful and the program was installed in a large number of groups throughout the state. The acceptance of the plan by groups in nonmetropolitan areas, as well as the urban centers where the original experimental installations were effected, has been gratifying. On December 31, 1957 a total of 51 groups with 9,000 employees were covered by Special Service. This provided protection for approximately 22,500 persons. On December 31, 1958 coverage had expanded to 507 groups with 23,500 employees and a total of 59,000 persons protected. The map above shows the geographical distribution of Special Service contract groups. The Commission feels that this distribution is encouraging in that it shows WPS–Blue Shield coverage in most all areas of the state.

In addition to the basic Special Service program with its benefits for surgery, maternity, in-hospital medical care, anesthesia and x-ray associated with surgery and maternity, and radiation therapy, it is possible for groups to purchase a major illness extension. It is anticipated that groups will show increased interest in this more comprehensive type of program in the future.

TOTAL SURGICAL–MEDICAL CONTRACTS IN EFFECT

	January 1 1958	*December 31 1958*	*Net Change*
Remitting through group employer	113,366	81,879	(31,487)
Direct payment by subscriber	29,270	27,125	(2,145)
Total	142,636	109,004	(33,632)

SURGICAL–MEDICAL CONTRACTS BY TYPE

	January 1 1958	*December 31 1958*	*Net Change*
"A"	64,744	42,625	(22,119)
"B"	68,541	40,640	(27,901)
Special Service	9,351	25,739	16,388
Total	142,636	109,004	33,632

HOSPITAL CONTRACT GROWTH*

1958	*Remitting Through Group Employer*	*Direct Payment by Subscriber*	*Total*
August	1,330	4,381	5,711
September	4,749	9,567	14,316
October	7,204	14,515	21,719
November	9,716	16,970	26,686
December	14,379	19,040	33,419

*All except a minor percentage of these contracts are carried by subscribers who also have WPS–Blue Shield surgical-medical benefits.

Note: Each subscriber is counted as one "contract." A subscriber carrying both surgical-medical and hospital coverage would still be counted as one "contract." As a rule of thumb, there are about 2.5 persons (subscriber and dependents) covered under each "contract."

THE BLUE SHIELD PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN

WPS

WISCONSIN PHYSICIANS SERVICE

SALES STAFF AND OFFICES

Types of Contracts and Riders Available

The ability of WPS–Blue Shield to meet the needs of the people of Wisconsin is greatly enhanced by the availability of a variety of contracts and riders authorized by the Commission. From the following list of contracts and riders available through WPS–Blue Shield, it is obvious that the plan is rapidly extending its protection mechanisms to provide benefits for virtually all types of services rendered by physicians.

Basic Coverages Available to Employed Groups:

"A" Schedule Group Service Contract
"B" Schedule Group Service Contract
Special Service Contract (full payment)
Hospital Expense Rider—room rates of $8.00 to $18.00 per day

Riders Available for Employed Groups:

Surgical–Medical–Hospital
- Waiver of obstetrical and pre-existing condition waiting periods
- Waiver of pre-existing condition waiting periods
- Specific Disease Rider—Limits of $2,000 to $10,000
- In-patient Diagnostic Rider
- Radiation Therapy Rider
- Maternity benefits on a single contract
- Diagnostic X-Ray and Laboratory Services Rider
- Dependent students covered to age 23

Surgical–Medical Only
- Exclusion of medical benefits
- Medical care extended to 70, 120 or 360 days
- First day coverage for the infant
- Home and office medical rider
- Ambulance service rider

Hospital Only
- Extended days of care for hospital care
- Extended days of care for maternity cases
- Endorsement excluding surgical–medical coverage

Coverage Available to Subscribers Leaving Group Employment:

"A" Conversion Service Contract
"B" Conversion Service Contract
"A" or "B" Conversion Service Contract—without medical benefits
Hospital Expense Rider—room rates of $8.00 to $18.00 per day
Century Plan for persons age 65 or over

The Commission is currently considering the expansion of its available coverages so that conversion subscribers may be offered some or all of the riders previously available to them as members of employed groups. At the same time the Commission is considering the offering of the Special Service contract to both conversion and non-group subscribers.

WPS Hospital Expense Rider

On June 4, 1958 the Council authorized the Commission on Medical Care Plans to offer a WPS hospital expense rider in association with group and non-group surgical-medical offerings of WPS. The rider has been widely accepted. As is true of all WPS contracts and riders, the offering of the hospital rider was filed with and approved by the Wisconsin Department of Insurance.

The following is a brief summary of WPS hospital expense rider benefits which are available for charges billed by general hospitals anywhere:

Length of Stay—Room and board and miscellaneous expense benefits up to 120 days per admission.

Room and Board—Hospital charges will be paid toward private, semi-private or ward accommodations up to the daily room benefit purchased . . . $8.00 to $18.00 per day

Miscellaneous Patient Expense—Full payment of *all* regular hospital charges for miscellaneous expenses necessary for the treatment of injuries, sickness or disease.

Maternity Care—Hospital charges for both mother and child will be paid up to ten times the selected room and board rate for each pregnancy.

Out-Patient Hospital Benefits—Full payment will be made of all miscellaneous hospital expense incurred on the *initial* out-patient visit:

a. On account of injury if the visit occurs within 48 hours of the injury.
b. On account of other out-patient surgery.

Care for Nervous and Mental Disorders—When a patient is admitted to a general hospital for a nervous or mental disorder, regular contract benefits (room, board and miscellaneous services for 120 days per admission) will be available. When admitted to a sanitarium, the room and board charges (without miscellaneous expenses) will be paid up to the amount of the daily room benefit purchased for a maximum of 70 days.

Century Plan for the Aged

The State Medical Society has responded to the American Medical Association's challenge, issued last December, to provide special mechanisms to insure the injury and illness expense needs of our aging population. Actually the plan has been in the making for several years. Through WPS–Blue Shield the Commission has announced the "Century Plan" for Wisconsin citizens who are 65 years of age or older. It is estimated that some 330,000 persons in Wisconsin are in this age bracket.

The Century Plan will be offered statewide on May 1, 1959. Descriptive literature will be sent to the offices of practicing physicians. No policy will be issued to be effective before May 1. This is another important "first" for the State Medical Society's Blue Shield plan. A brief description of the program follows:

CENTURY PLAN

Anyone 65 years of age or older may enroll. Protection for those who are enrolled is effective immediately *except for:*

(1) Conditions for which treatment has been received during the past year;

(2) Or which existed on the effective date of coverage;

(3) Or any of the following: Appendix, Benign Tumors; Cystocele or Rectocele, Gallbladder, Hemorrhoids, Indirect Hernia, Prostatic Condition, Uterus (including Tubes and Ovaries), and Varicose Veins.

However, benefits for such exceptions will be available after a nine month waiting period.

Monthly premiums for the plan have been set at $9.00 per person. There is no family plan.

Physicians' Services

1. Benefits for physicians' services are provided as follows:
   a. Surgical Services, wherever performed.
   b. In-Hospital Medical Services for patients admitted to a general hospital for up to 60 days for each illness for which hospital benefits are payable.
   c. Anesthesia Services, when associated with surgical services.
   d. Diagnostic X-ray Services, when associated with surgical services.
   e. Radiation Therapy Services, for proven malignancies (full payment provision does not apply).
2. Benefits paid by Wisconsin Physicians Service according to the "B" schedule in effect at the time of the service rendered are to be accepted by participating physicians as full payment, if an individual's annual income is $2,000 or less, or a man and wife's combined annual income is $3,600 or less.

Institutional Care For Conditions Other Than Nervous and Mental

Hospital Benefits—for patients admitted to a general hospital

Hospital benefits are provided for the first 60 days of each illness. During this period, the Century Plan will provide up to $10.00 per day for room and board expense, plus benefits for miscellaneous hospital expenses as defined in the contract.

Nursing Home Benefits

Nursing home benefits are available within the same 60 day period, but only when the patient is transferred directly from a general hospital to a nursing home, allowing a reasonable time interval for necessary travel. In such case, the Century Plan provides up to $10.00 per day for room and board charges, but not for miscellaneous expense.

Duration of Benefits

Hospital and nursing home benefits are limited to a combined total of 60 days per illness. However, if there is a period of 60 days between the date of discharge from a general hospital or nursing home and the date of the next admission to a hospital for the same illness, a new 60 day benefit is available.

Institutional Care For Nervous and Mental Illness

Wisconsin Physicians Service will pay only the room and board expense incurred for confinement in a general hospital, nursing home or sanitarium, up to $10.00 per day for a maximum of 60 days during the life of the subscriber. Again there must be a direct transfer (with reasonable travel time) from a general hospital in-patient confinement for immediate admission to the nursing home or sanitarium.

Miscellaneous Other Provisions

Out-Patient Hospital Benefits

Out-patient hospital benefits are payable for the first visit because of surgery or within 48 hours of injury.

Exclusions

The usual standard exclusions will apply.

MEDICARE

Medicare, the military dependents' medical care plan of the United States government, is administered in Wisconsin by the State Medical Society. Its operation is supervised by the Commission on Medical Care Plans. The Medicare program in 1958 began its second full year of operation. The program provides hospital and physician care to dependents of military personnel through civilian facilities. In Wisconsin $416,000 was paid out on nearly 5,800 claims during 1958. This represents an increase of $133,000 over payments made in the year 1957. Obstetrical care continues to be the major portion of the Medicare program. Fifty per cent of total payments were made for this area of service.

In July, 1958 the Medicare program was changed to discontinue the availability of payment for drugs and medications provided to obstetrical patients. Effective October 1, 1958, substantial cutbacks in the program were accomplished in the following areas.

A. Benefits no longer provided:

1. Treatment of accidental injury cases or illnesses not requiring hospitalization.
2. Diagnostic tests provided on an out-patient basis.
3. Treatment of nervous and mental diseases.
4. Elective surgery.
5. Other out-patient services for newborn.

B. Dependent residing with sponsor:

In those cases where dependents reside with the serviceman, they are no longer eligible for care through civilian facilities unless the nearest uniformed medical service facility cannot provide the type of care required. In that event the dependent must obtain a certificate from the commanding officer of the medical facility authorizing care through civilian facilities. Dependents residing apart from the serviceman continue to be eligible for care through civilian facilities.

It is anticipated that these restrictions will result in a reduction of Medicare payments during 1959; however, it will require additional administrative expense because of the detailed checking which has to be accomplished based on the changes outlined above.

In the opinion of the Commission, the restrictions which were put into effect in October went beyond the original intent of the Medicare program. Accordingly, the Commission advised the President of the United States, both Wisconsin Senators and the Office of Dependents' Medical Care of Wisconsin objection to the cutback in the program. Numerous other state medical societies charged with the administration of Medicare took similar action. In spite of these objections, the Office of Dependents' Medical Care installed the restrictions without change and little choice was left as to acceptance or rejection of the responsibility of administration by the numerous state medical societies involved. Undoubtedly, as Congress becomes more budget conscious, additional restrictions will come about. The cutbacks already put into effect have caused many servicemen to apply for health insurance coverage through other sources as a means of supplementing the now restricted Medicare program benefits. Possibly the ultimate solution will be that originally offered by Wisconsin suggesting that the problem of medical care for service dependents be solved through the purchase of voluntary protection presently available on the insurance market.

WISCONSIN PLAN

Eight commercial insurance carriers continue to participate in the "Wisconsin Plan." This approach to voluntary health insurance coverage was authorized by the House of Delegates in 1945. Basically, it permits commercial insurance carriers who subscribe to minimum specifications established by the State Medical Society to sell the "A" and "B" scheduled programs of the Society under the name "Wisconsin Plan."

The companies currently participating in this effort are:

Business Men's Assurance Company, Kansas City, Missouri

Hardware Mutual Casualty Company, Stevens Point, Wisconsin

Continental Assurance Company, Chicago, Illinois

Rural Mutual Insurance Company, Madison, Wisconsin

Liberty Mutual Insurance Company, Milwaukee, Wisconsin

Employers Mutuals Insurance Company, Wausau, Wisconsin

John Hancock Mutual Insurance Company, Boston, Massachusetts

Association Insurance Company, Milwaukee, Wisconsin

The Claims Committee and the Claims Department of the Commission on Medical Care Plans provides consulting advice on unusual claims submitted by these companies. During 1958 a total of 93 such cases were submitted to the Claims Department for advice and guidance. The companies involved reimbursed the Society for expense associated with this service.

WISCONSIN VETERANS MEDICAL SERVICE AGENCY

The contract between the Veterans Administration and the State Medical Society of Wisconsin for "Home Town Medical Care" has continued during 1958. The Veterans Administration during that year provided payment in the amount of $130,840.48 for physicians' services rendered to veterans with service connected disabilities.

As reimbursement for providing its administrative and advisory services to the Home Town Care program, the Wisconsin Veterans Medical Service Agency of the State Medical Society was paid a total of $12,514.69 in 1958 by the Veterans Administration.

The contract between the Veterans Administration and the State Medical Society of Wisconsin is on a fiscal year basis. In late 1958, it became known

that the Veterans Administration wished to renegotiate the contract on a more limited basis. It appears to be the desire of the Veterans Administration to perform all of the administrative work in connection with the Home Town Care program. The Veterans Administration requests that the Medical Society Agency be responsible only for furnishing a list of participating physicians, maintaining a fee schedule, establishing an advisory committee, assisting in maintaining sound public relations and possibly writing checks to physicians after all other administrative functions have been completed by the Veterans Administration.

The State Medical Society can do little if the Federal Government decides it no longer wishes to purchase administrative assistance from the State Medical Society of Wisconsin. The Commission believes there is marked advantage in having the State Medical Society Agency do the negotiating with the Federal Government rather than having each county or each individual physician working out a fee schedule arrangement with the Veterans Administration.

The negotiations on the proposed contract for the fiscal year 1959–60 will be continued through the Commission.

Respectfully submitted,

COMMISSION ON MEDICAL CARE PLANS

E. M. Dessloch, M.D., Prairie du Chien, *Chairman*

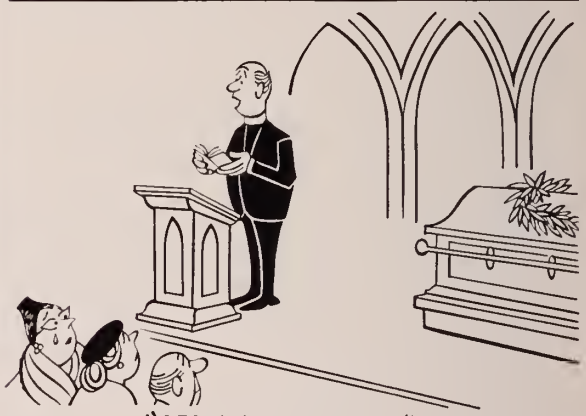
Robert Krohn, M.D., Black River Falls, *Vice Chairman*

N. A. Hill, M.D., Madison, *Treasurer*
John T. Sprague, M.D., Madison, *Assistant Treasurer*

H. A. Aageson, M.D., Oconto
G. W. Carlson, M.D., Appleton
W. T. Casper, M.D., Milwaukee
Milton D. Davis, M.D., Milton
K. H. Doege, M.D., Marshfield
Milton Finn, M.D., Superior
R. E. Garrison, M.D., Wisconsin Rapids
D. N. Goldstein, M.D., Kenosha
A. W. Hilker, M.D., Eau Claire
R. S. Hirsch, M.D., Viroqua
A. J. McCarey, M.D., Green Bay
P. B. Mason, M.D., Sheboygan
R. M. Moore, M.D., Frederic
E. J. Nordby, M.D., Madison
C. G. Reznichek, M.D., Madison
L. O. Simenstad, M.D., Osceola
J. S. Supernaw, M.D., Madison
F. H. Wolf, M.D., La Crosse

Ex Officio:
W. B. Hildebrand, M.D., Menasha, *President*

"BYE, BYE, MADGE. SEE YOU IN CHURCH."



"DEARLY BELOVED...."

More Than 253,000

Pedestrians Were Killed

or Injured During 1958

—A 10% Increase Over 1957

Thirty-five per cent of the 7,700 pedestrians killed during 1958 resulted from crossing between intersections. Of the 245,800 pedestrians injured in 1958, one-fourth were the result of the same actions. Crossing at intersection with no signal accounted for 13.8% killed and 11% injured. Coming from behind parked cars accounted for one-fifth of injuries.

INFORMATION COMPILED FROM *THE LUCKLESS LEGION*, PUBLISHED BY THE TRAVELERS INSURANCE COMPANIES, HARTFORD, CONNECTICUT

Minutes of Council Meeting, Madison December 13–14, 1958

1. Call to Order and Roll Call

The Council was called to order by Chairman Arveson at 2:00 p.m. on Saturday, December 13, 1958.

Councilors present were Doctors James, Lokvam, Hill, Houghton, Dessloch, Blanchard, Kief (Saturday only), Garrison, Arveson, Ekblad, Bernhart, Conley and Conway (Saturday only).

Officers and others: President Hildebrand; Doctors Stovall (Saturday) and Simenstad, AMA Delegates; Doctors Beatty, Cowan, Habbe, and Golden representing the Wisconsin Radiological Society (Saturday afternoon).

Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Reynolds, Neese (Saturday), Mrs. Anderson, Miss Pyre; Messrs. Murphy and Desmond, legal counsel; Mr. Gill, certified public accountant; Mr. Tiffany, consulting actuary.

2. Specialty Services in the Prepaid Movement

Doctors Beatty, Cowan, and Habbe discussed with the Council at considerable length the position of the Wisconsin Radiological Society as expressed in the following resolution:

WHEREAS, the practice of radiology is the practice of medicine, and

WHEREAS, the tradition of American Medicine demands that a physician maintain full control over his methods of procedure and assume full personal responsibility for the care of his patients;

THEREFORE, in the public interest, and in the interest of the welfare of their patients, the members of the Wisconsin Radiological Society, Inc., do assert and maintain:

First, that the patients receiving radiologic services should be billed only by, or in the name of, a physician qualified to perform such services;

Second, that the insurance benefits payable in a patient's name for radiologic services should be transferred from the Blue Cross, or any hospital plan, to Blue Shield, or a similar plan covering medical services;

Third, that it is contrary to the public interest for an insurance plan to require hospital admission or attendance as a prerequisite for the payment of radiologic benefits.

The representatives of the Wisconsin Radiological Society are authorized and directed to present these opinions to any interested body as the considered opinions of the members of this Society.

Doctor Dessloch told the Council that radiology representatives have met with the Commission on Medical Care Plans, which has assured them that it will accomplish the inclusion of radiology, pathology, anesthesiology and physiatry services in the WPS surgical-medical contracts as rapidly as is feasible. However, he felt that the specialists were correct in bringing their requests to the Council, since the Commission's position is that problems of medical practice should be solved through organized medicine and not through insurance mechanisms. He reminded the Council that the Commission agrees wholeheartedly that the practice of these specialties is the practice of medicine, and their inclusion in Blue Cross contracts was opposed from the very beginning.

On motion of Doctors Lokvam–Dessloch, carried, the Council recorded its accord with the principles enunciated in relation to radiology, pathology, anesthesiology, and physiatry, and will aid in every way it can to further those principles.

3. Report of the Executive Committee

a. Hypertension survey of the State Board of Health

The blood presure reading program through the mobile units of the State Board of Health had been cleared with the Division on Chest Diseases and the Commission on State Departments during the year, but had not received official consideration or approval by the Society through the Council. A county society had questioned the Society's position concerning this activity.

The Executive Committee reviewed committee action on the matter, and recommended that the official position of the Society be that this survey be conducted in any county society only with its express approval.

On motion of Doctors Dessloch–Houghton, carried, the Council affirmed the position of the Executive Committee.

b. Chiropodists' position on Society's statement on associations with ancillary personnel

The Wisconsin Society of Chiropodists had requested reconsideration to the inclusion of chiropodists in the "Statement of Ethical Principles" adopted by the Council in March, 1958, and recorded in its minutes.

The Executive Committee reported that it had discussed the matter at its meeting on December 2, and recommended no change in the statement at this time.

The recommendation was approved on motion of Doctors Conway–Ekblad, carried.

c. Wisconsin Pharmaceutical Association

The Executive Committee recommended approval to the proposal by this association of a cooperative program of publishing information on narcotic prescriptions.

The Council approved, on motion of Doctors Hill-Lokvam, carried.

d. Resignation of Jerome W. Fons, M.D.

Through a letter from Doctor Lokvam to Doctor Leahy, the Executive Committee learned and reported to the Council that the special committee of the House, charged with contacting Doctor Fons, failed to secure reconsideration of his resignation as president of the State Medical Society.

On motion of Doctors Ekblad–Conway, carried, the Council asked that this be formally recorded and reported to the House for its information.

e. Miscellaneous

The Executive Committee reported that it hoped to meet monthly in the future; also that it would undertake a study of the subject of corporate practice, including the statement of the Ohio State Medical Association.

4. Report of the President

Doctor Hildebrand reported his presidential objectives to the Council in the areas of insurance difficulties, legislation, and intraprofessional relations.

5. Report of Committee on Hospital Relations

The Council had requested a report of new field activities under general direction of this committee for consideration of proper budgetary allocation in 1959.

The Committee on Hospital Relations met in November and received a detailed report on the field service to medical staffs of hospitals in Wisconsin, which was also reviewed in detail by the Council, including these committee recommendations:

a. Continue the field service program in physician-hospital relations with emphasis on contact with the entire medical staff of each hospital.
b. Establish, at an early date and on a continuing basis, a clear interorganizational relationship with the Wisconsin Hospital Association for purposes of evaluating the program and improving its effectiveness to the benefit of members of both organizations and the public.
c. Improve communications between the WHA and State Medical Society by exchange of information in journals, and so forth.
d. Study of accreditation procedures in Wisconsin hospitals.
e. Study of development of hospital and related facilities in Wisconsin, especially as such planning may be affected by the Hill–Burton Act, preferably in conjunction with the WHA and the State Board of Health.

On motion of Doctors Dessloch–Conway, carried, the report was accepted by the Council, with commendation to Mr. Neese, and forwarded to the House of Delegates.

6. Report of the Commission on Medical Care Plans

Doctor Dessloch reported as follows concerning the December 1958 quarterly meeting of the Commission:

"The 31st meeting of the Commission on Medical Care Plans was called for Minneapolis, this being as convenient to its members as any location in Wisconsin, and having the added advantage of permitting the members opportunity to be at hand during sessions of the House of Delegates of the AMA which considered important subjects in the area of prepaid health care plans.

"*Operating Organization.* The volume of activity caused by WPS–Blue Shield becoming its own agent, and being forced to enter into the area of hospital costs protection by refusal of Blue Cross to provide a companion plan, necessitated rapid developments of total implementation in June, 1958. On authority of the Council, your Secretary and general manager secured the services of a management consultant who aids the staff in implementing certain aspects of our new operation and who has been studying our operational organization. Mr. Herman L. Toser of Stevens Point has served in this capacity. For some 25 years he has been associated with Hardware Mutuals until establishing his own business a year and a half ago. The Commission heard Mr. Toser's report at its December meeting, and is satisfied that matters are well in hand.

"Some procedures have been re-evaluated and streamlined. Duties of the staff are being reassigned in some minor respects to produce more logical handling. The major development is the creation of an Underwriting Department along the lines generally accepted as necessary in the operation of this type of activity.

"Space necessary to house additional activities and employees has been secured in the Farm Bureau, approximately 2½ miles from the Society's building. In 3,300 square feet, costing $10,800 in annual rent, are now housed the total Accounting Department and the coverage records which are kept in three 'tub' files, each 15 feet in length. Thirty-three employees are located in this branch office.

"*Commission Organization.* As in the case of operational activities, changes in some respects are indicated in the Commission structure itself. There are 26 appointed members, plus the president and president-elect, for a total of 28 physicians in direction of WPS–Blue Shield and other responsibilities assigned the Commission.

"It is agreed that the Executive Committee should henceforth meet monthly and should be enlarged. Other committees will also be increased in size, and two should be combined in the interest of efficiency. The Council, in establishing the Commission, specified the committees but left their composition to the Commission itself. Thus, when the Commission felt the necessity of a committee specifically concerned with the hospital contract, it was necessary to seek Council approval. Your Chairman feels that this is needless procedure at this time, and recommends that the Council, by acceptance or other action upon this report, permit the Commission henceforth to organize itself as to committee structure.

"I should like to add that much of the discussion revolved around the responsibility of members of the Commission. It was generally agreed that each member should assume the responsibility of attending appropriate meetings with the staff and following more closely not only current developments but now more of the planning for the future. Quarterly financial reports will be printed in the *Wisconsin Medical Journal*, and plans are under way for an annual report to delegates even more comprehensive than those in the past.

"*Health Care of the Aged.* Governor Orville L. Freeman, of Minnesota, who addressed the opening session of the AMA, asked for 'the help of the leaders of the medical profession in working out a program that will most adequately meet the needs of our older citizens for health care and services of the highest quality.'

" 'Responding to Doctor Gundersen's call for action and Governor Freeman's plea for help' in meeting the health care needs of the aged, the House of Delegates adopted the following proposal submitted by the Council on Medical Service and endorsed by the Board of Trustees:

" 'For persons over 65 years of age with reduced incomes and very modest resources, it is necessary immediately to develop further the voluntary health insurance or prepayment plans in a way that would be acceptable both to the recipients and the medical profession. The medical profession must continue to assert its leadership and responsibility for assuring adequate medical care for this group of our citizens.

" 'Therefore, the Council on Medical Service recommends to the House of Delegates the adoption of the following proposal: That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate.'

"This subject is not new to WPS–Blue Shield. With some pride we can point out that several years ago provision was made to finance a special study by the School of Commerce of the University of Wisconsin. Other steps have been taken.

"However, the report of the AMA precipitates developments in this field. (Here Doctor Dessloch referred to communications from the national association of Blue Shield plans announcing their preparedness to help meet the AMA objective, and suggesting that local plans develop programs reasonably uniform in terms of benefits and rates.)

"A word of caution . . .

"Plans should not be so hurried that the contribution to this area of their coverage fails of its objective, or completely nationalizes the program. The ingenuity which has characterized WPS–Blue Shield from its beginnings, and which has made it one of the top plans of the country in its leadership, should now characterize it once again. By no means are we ready to propose, necessarily, to accept a 'pattern of coverage, fees, and rates' to achieve 'a uniform offering.' But this is premature comment upon an urgent matter. I am satisfied that Wisconsin physicians will receive constructive action from WPS–Blue Shield which, of course, must clear the Council before it can go further.

"*Commission on Medical Care Plans of the AMA.* The long-awaited report of the Commission on Medical Care Plans, appointed at the 1954 Clinical Meeting in Miami, was discussed for two hours at a reference committee hearing, but the House decided to defer action until the June, 1959, meeting. In so doing, the Delegates adopted this statement:

" 'We respectfully suggest to the constituent associations reviewing the report in the interim, that their attitude regarding the report will be clarified if they arrive at some decisions in regard to the following basic points:

" '1. Free Choice of Physician—Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

" '2. Closed Panel Systems—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

" 'These suggestions acknowledge that the policy of the American Medical Association to encourage and support the highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change.'

"The House recommended that the Board of Trustees invite the constituent associations to forward their replies to these questions to the Executive Vice President 60 days in advance of the June, 1959, meeting.

"This subject will also be studied by the Commission with subsequent report to the Council.

"*Extension of Surgical Care into the state.* The Council will recall its action of September, reported to the House, to the effect that the Insurance Commissioner and the national association of Blue Shield plans be notified that the extension of Surgical Care into the state is disapproved. This action has not been implemented, and the Commission recommends to you that official communications be forwarded on this matter at once.

"A related resolution was adopted at the same meeting suggesting that county societies poll their membership on the desire to participate in Surgical Care. At least two counties have filed requests with The Medical Society of Milwaukee County for a list of participants. The Milwaukee society has refused. This information should be carried back into their respective areas by the Councilors and Officers, and the Commission recommends that county medical societies be reminded of this September action.

"*Resolution of the Dane County Medical Society.* The intent of this resolution was considered by the Commission. It understands that by action of the House, Blue Shield in Wisconsin is directed to become one in the sense that both plans are under final direction of the House as to policy matters. Surgical Care of Milwaukee continues as a plan franchised to that area, and to that area alone. Other plans of the future will be dealt with specifically as they may be proposed.

"*Position on Legislation affecting the 'Blue Plans.'* This matter was reviewed by the Commission acting upon a report by consultants Murphy, Tiffany, and Toser. The Commission recommends to the Council that it express the position of the Society as stated in the following guides:

"1. The State Medical Society initiate no supervisory or regulatory legislation for any of the Blue Plans in the 1959 session of the Wisconsin Legislature. This would not foreclose the Society from offering amendments to legislation proposed by others which were deemed necessary either to correct substantial errors in such proposed legislation, or to make possible the inclusion of the points detailed in the recommendation which follows:

"2. In order to have the support of the Society, any bill or amendment relating to the supervision or regulation of the Blue Plans should contain one or more, and preferably all, of the following provisions:

"(a) Formal requirement for the submission of annual reports by all plans. Blue Cross is now required to submit such a report. WPS has done so voluntarily; Surgical Care is reported to assert that it is exempt from such a requirement. This is believed a fundamental part of any minimal legislation intended to provide the constructive supervision of the Insurance Department.

"(b) Approval of all contracts by the Insurance Department. Since its organization, WPS has filed all contract and other forms. Since 1945, the statute has empowered the Commissioner of Insurance to approve the form but not the content of contracts of medical care plans. While the statute does not extend to content, WPS has always been cooperative on this point. It is reported that Blue Cross and Surgical Care have filed some forms from time to time, but that Surgical Care does not feel obligated to do so. Blue Cross is not required by statute to file its forms. The Blue Plans and not the Insurance Department must retain the ultimate right to determine areas and extent of coverage.

"(c) Require an examination by the Insurance Department every three years of the operations of plans under Chapter 148 (WPS and Surgical Care). The statutes now require an examination of Blue Cross at least that often, but there is no similar provision for WPS or Surgical Care.

"(d) Licensure by the Insurance Department of all persons who sell or directly supervise the sale of Blue Cross or Blue Shield programs.

"(e) Payment of some kind of fee in lieu of taxes. WPS has long been favorable to such an idea, but it should be worked out carefully with the insurance companies so as not to set a precedent unacceptable to them.

"(f) Volunteer no public rate control, and oppose any proposal to vest this power in the Insurance Department. The chief reasons for such opposition are first, that the Blue Plans would be at a marked competitive disadvantage by comparison with the commercial companies, since the latter are not subject to rate control on health policies; second, that health legislation is subject to heavy pressures from the public because of the preoccupation of many people with their personal health problems. This can bring rates into the political arena instead of leaving them as matters of profesional and competitive judgment.

"This recommendation includes making the Society's position known, it being understood that the Society will not seek the introduction of such legislation but will use this statement as a test of its support to proposals which may originate elsewhere.

"*Study of Hospital Insurance.* The Commission believes this one of the important public service

developments of the recent special session. In the short time since, it has not been possible to fully delineate its recommendations, which it will offer to a subsequent meeting of the Council. For the information of this body, however, it wishes to report its understanding that since the special session of the House, Blue Cross has itself initiated a special study which it is understood is based upon experience of some 30 hospitals in the state. This study appears to be limited to costs alone, and does not enter into other considerations contained in the House action.

"*Usage of 'Blue Shield'* as symbol and trade name by Blue Cross, as agent, and by Surgical Care of Milwaukee, as constituting unfair trade practice.

"The House affirmed that this be presented to the Insurance Commissioner. The Commission believes that the Council should have before it a detailed accounting and that the total problem should be presented. While certain advertisements and literature have been collected, the project as a whole has not been completed. The Commission therefore recommends that this action be held for a subsequent meeting.

"*Assessability of SMS members for WPS liabilities.* There was filed with the Commission an opinion of the Society's attorneys upon this subject. In some manner a rumor has been circulated that should WPS be unable to discharge its contract liabilities, SMS members would be personally liable. This is, of course, untrue. The Commission accepted the report, which is quoted, in substance, as follows:

"We have been asked for an opinion on the following question:

"Are members of the State Medical Society of Wisconsin individually liable under the law of this state, by per capita assessment, for obligations incurred by Wisconsin Physicians Service (WPS)?

"After a search of the legal authorities . . . our conclusion is that there is *no* such liability under Wisconsin law.

"If any such liability existed, it would be by virtue of: (1) the Wisconsin Statutes; (2) court law; or (3) contract. There is clearly nothing in any of the contracts issued by Wisconsin Physicians Service which expressly or impliedly creates an assessment or other liability on the part of members of the State Medical Society for claims or other debts owed by WPS.

"WPS is a division of the State Medical Society and not a separate legal entity. The State Medical Society was created as a corporation by the Territorial Legislature in 1841, and has so continued ever since then by acts of successive Legislatures. The Society has the general powers and characteristics of a corporation. One such characteristic is that a corporation provides a kind of legal 'insulation' between its stockholders or members and its creditors.

"It is a general rule of law that in a stock company there is no personal liability for assessment against a person who is not a stockholder. The State Medical Society is a nonstock corporation; hence there are no stockholders, and there can be no assessment liability.

"To conclude, we find nothing in the Wisconsin Statutes, the general corporation law of this state, or the contracts issued by WPS, which would impose an assessment liability on members of a nonstock corporation such as your Society.

"Should you wish any part of this opinion more fully developed, please so advise.

"This concludes the principal items of Commission consideration."

On motion of Doctors Dessloch–Garrison, carried, the report of the Commission was accepted and its recommendations adopted.

7. Study of County Society Constitutions and Bylaws

By action of the Council in July, 1958, the Secretary had been directed to call in for study the constitution, bylaws and regulations of all component county medical societies.

It was suggested that a Council committee be assigned the project of their review and analysis, and on motion of Doctors Ekblad–Blanchard, carried, this was referred to the Planning Committee.

A related matter concerned action by the House at the September special session, on recommendation of the Council, that the constitution and bylaws of county societies be amended in such manner as to give assurance that a county medical society will not conduct functioning programs beyond its geographic area. Such action called for accomplishment of this directive by the end of 1958.

The Secretary made a progress report to the effect that several county societies have adopted such amendment, some have reported inability to meet the deadline due to meeting schedules, and at least one county society had independent legal advice to the effect that formal action was not necessary inasmuch as it does not engage in activities beyond its boundaries, and it is inherent in the structure of county societies that they exist for a specific area only.

Following discussion, the subject was laid over for later consideration. The Council then recessed at 5:35 p.m., until Sunday morning, December 14.

8. Employees' Pension Plan

In 1957 the Council had authorized an amendment to the pension plan to permit participation of part-time employees earning at least $5,000 annually, subject to approval of the Internal Revenue Service.

Doctor Dessloch reported that the federal government would approve the plan for a part-time employee providing the amount of earnings are not stipulated.

On motion of Doctors Dessloch–Hill, carried, the words "earning at least $5,000 annually" were stricken from the past action.

9. Council on Scientific Work

Mr. Ragatz described the proposal for 1959 of promoting scientific programs for county society and councilor district meetings. The Council on Scientific Work hoped for a budgetary allocation from the State Medical Society and expected further financial support from the State Board of Health and voluntary agencies in arranging these programs and providing speakers.

10. Press–Radio Code

The Council reviewed in detail a semifinal draft of the code prepared by the Council on Medical Service. Suggestions offered were that the sheriffs' association be included in its distribution, and that a section or statement on use of the title "doctor" be incorporated.

The Council believed that final action need not await the annual meeting of the House of Delegates, and on motion of Doctors Lokvam–James, carried, the code was approved subject to final editing, and the Council on Medical Service commended for its efforts.

11. Resolution of Congratulations

On motion of Doctors Dessloch–Hill, carried, the Council extended congratulations to Clifford Lord, past director of the State Historical Society, and asked that an appropriate resolution be sent to him at his new post with Columbia University.

12. Specialties and State Administrative Boards

Attention had been directed to an inconsistency in policy of two state departments regarding the use of orthopedic consultants. The Bureau for Handicapped Children, based upon a recommendation of the Society of some 18 years' standing, requires Board certification, while the Vocational Rehabilitation Division utilizes the services of Board certified, Board qualified, or physicians recognized as qualified in their local community.

The Council thought that this suggested the advisability of a broader study, and on motion of Doctors Hill–Garrison, carried, was referred to the Commission on State Departments for study and report to the Council.

13. Appointments to State Boards

The Secretary reminded the Council that the Society is permitted by statute to submit a panel to the Governor for his consideration in making appointments to the State Board of Medical Examiners. He said that several terms were expiring in 1959, and asked Councilors to make known their recommendations for submission through mechanisms of the Executive Committee.

14. Tissue Committees

Mr. Murphy reported on a recent conference of the Joint Commission on Accreditation of Hospitals attended by representatives of the North Central Conference states. This was informational, no action being taken.

15. Legislative Proposal

Doctor Hildebrand presented a request for Society support of legislation providing for a fee to be paid the state by adoptive parents. Such legislation had not been submitted in draft form, and following discussion the Council suggested that Doctor Hildebrand inform his correspondent that while the Council informally felt the proposal had some merit, it wished to defer any action until the legislation could be specifically reviewed.

16. Adjournment

The Council adjourned at 12:00 noon on Sunday, December 14, 1958.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M.D.
Chairman of the Council

Minutes of Council Meeting, Madison February 28–March 1, 1959

1. Call to Order and Roll Call

The annual meeting of the Council was called to order by Chairman Arveson at 2:00 p.m. on Saturday, February 28, at Society headquarters in Madison.

Councilors present were Doctors James, Lokvam, Houghton, Dessloch, Blanchard (Saturday only), Kief, Fox, Bell, Arveson, Ekblad, Bernhart, Conway, Kilkenny (Saturday afternoon), Leahy, and Past President Kasten.

Officers and others present: Doctors W. B. Hildebrand, president; F. L. Weston, treasurer; J. C. Griffith (Saturday) and L. O. Simenstad, AMA delegates; A. H. Heidner, councilor emeritus; A. A. Quisling (Saturday afternoon), chairman, Committee on Public Policy.

Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Doran, and DuBois; R. B. Murphy, legal counsel, and J. B. White, accounting consultant; Miss Pyre; Mrs. Anderson (Saturday) and Miss Cordts (Sunday).

2. Approval of Minutes

On motion of Doctors Blanchard–Bell, carried, minutes of the following meetings were approved as published in the December Journal: March 1–2, May 4–6, June 4, July 25–26, September 13, and September 27, 1958.

3. New Business

These matters were added to the foot of the calendar:

Doctor Ekblad proposed that a regular date be scheduled for the annual meeting of the Council each year.

Doctor Lokvam asked for discussion of a special committee to be appointed by President Hildebrand to meet with a committee of the Milwaukee County Board of Directors.

Doctor Heidner requested opportunity to discuss the American Medical Education Foundation.

4. Election of Officers

Doctor Arveson announced that he was not a candidate for chairmanship of the Council under any circumstance, and thanked the councilors for their kind consideration over the years.

On motion of Doctors Ekblad–Lokvam, carried, the election of officers was deferred until later in the agenda.

5. District Caucuses

Pursuant to Council action requesting the administrative staff to arrange a schedule of delegate caucuses in each councilor district, Mr. Ragatz presented a proposed calendar of meetings during the month of April, invitations to be extended by the councilor to delegates and alternates, county society officers, and any committee chairmen, members of the Commission on Medical Care Plans, or past presidents located within a district.

On motion of Doctors Bell–Dessloch, carried, the procedure was accepted; dates and meeting places to be cleared with individual councilors.

6. Wisconsin Society of Chiropodists (Podiatrists)

After being advised of the Council's action in December not to change its statement on associations with ancillary personnel, the Wisconsin Society of Chiropodists (Podiatrists) wrote the Secretary, under date of February 23, requesting a meeting with the Council to discuss "problems created by the statement" for podiatrists.

On motion of Doctors Ekblad–Conway, carried, the Council requested that invitation to a meeting be extended to the podiatrists.

7. Bill 129, A.; SMS–WHA Liaison

Following a lengthy discussion of the purpose and implications of the bill, and reports by Doctors Quisling, Conway, and Hildebrand of committee and personal conferences with Wisconsin Hospital Association representatives, the Council took action as to the Society's position:

On motion of Doctors Dessloch–Bell, carried, the Public Policy Committee was instructed to oppose this bill.

Doctor Hildebrand requested approval to his appointment of a liaison committee to meet with the Wisconsin Hospital Association on long range problems of medicine and hospitals. There was considerable discussion as to whether a new committee should be created or the existing committee structure be utilized in this function.

Later in the meeting, following dinner recess, on motion of Doctors Bell–Conway, carried, the Council agreed that the committee consist of the president, chairman of the Council, and members of the Public Policy Committee to meet with any constituted committee of the Wisconsin Hospital Association to discuss liaison.

8. Mental Health Legislation

Doctors Quisling and Conway discussed Bills 1, 2 and 3–S, which had been under consideration by the Division on Nervous and Mental Diseases, the Commission on State Departments, and the Committee on Public Policy.

The recommended Society position on these bills was presented as follows:

Bill 1–S would abolish the present interdepartmental Commission on mental health composed of the administrative heads of the state boards of welfare, health, and public instruction, and in place thereof would create a State Mental Health Advisory Board to be appointed by the Governor and possessing its own administrative staff. It was being proposed that the 15-member advisory board include appointees from these state departments and also from certain designated nongovernmental organizations, including the State Medical Society.

Support of this bill was recommended, except that traditionally in the past the Society has been opposed to naming by statute organizations which are not state agencies for representation on state boards and committees.

Bill 2–S would remove direction of the child guidance clinics, established in local communities over a number of years as a pilot effort of the State Board of Health, to the State Department of Public Welfare. A system of state aids would be set up for their support, and they would become "all purpose clinics" serving adults as well as children, and follow-up of parolees and dischargees from all types of state institutions dealing with mental health.

The Public Policy and other committees recommended that this matter be referred to the Advisory Board proposed in Bill 1–S.

Bill 3–S relates to the proposal to create a treatment center for emotionally disturbed children. In May of 1958 the Council and House of Delegates had supported in principle the establishment of a treatment facility providing 25–30 beds, closely allied to the medical school, for teaching and research

purposes. Basic issues concerning the bill as introduced by the Legislative Council involved departmental jurisdiction, location and size, and medical direction and admission policies.

The Society committees recommended opposition to construction of a new building at an estimated cost of $500,000; utilization of existing facilities for a pilot study; selection of staff by the dean of the medical school on recommendation to the director of the State Department of Public Welfare.

On motion of Doctors Lokvam–Fox, carried, the Council accepted the recommendations concerning these three bills.

9. Use of Specialists by State Agencies

The Council had previously suggested study of this subject by the Commission on State Departments. A progress report was made by Mr. Thayer on behalf of the latter, which had held preliminary discussions with state department representatives concerned at its meeting on February 26.

10. Administration of "Pitocin"

An inquiry concerning the use of "pitocin" had been referred by the Council to the Division on Maternal and Child Welfare. Doctor Kilkenny reported the recommendation of the Division, approved by the Commission on State Departments, that he write a letter to the chiefs of medical staffs of Wisconsin hospitals concerning the values and dangers of oxytocic drugs and the need for direct supervision in their administration; also that an article on the subject be published in the *Wisconsin Medical Journal.*

On motion of Doctors Bell–Bernhart, carried, the report was accepted.

11. Adoption Procedures

The Division on Maternal and Child Welfare had met with representatives of the Division for Children and Youth of the Welfare Department on medical aspects of adoption procedures. Doctor Kilkenny reported that the Division had developed a proposed form for reporting fertility tests which it proposed to transmit to adoption agencies with the suggestion that they appoint a physician to serve as medical consultant and assume the responsibility of receiving medical reports and making recommendations to the agencies without revealing information of a confidential character.

On motion of Doctors Kilkenny–Blanchard, carried, the report form and recommendations were accepted.

12. Governor's Conference on Aging

The Council was asked to confirm participation by the Division on Geriatrics in 1959 and 1960 Governor's Conferences on Aging, preparatory to a President's Conference on Aging to be held in 1961, so that medicine will be adequately represented on this subject.

On motion of Doctors James–Bell, carried, the Council approved.

13. Resolution on Traffic Accident Prevention

On motion of Doctors Dessloch–Houghton, carried, the following resolution was adopted by the Council:

WHEREAS, traffic accidents each year kill more than 37,000 persons and injure another 1,400,000, causing not only tragic suffering and loss of life but costs exceeding five billion dollars in wage loss, property damage and medical services, and

WHEREAS, the attention of the nation has been effectively directed to some of the great problems and philosophies of human living through the issuance of special commemorative stamps as illustrated by the issues shown here, now, therefore be it

RESOLVED, that the Postmaster General of the United States be petitioned to issue annually, for five consecutive years, a special commemorative stamp on the theme of traffic safety, each year's stamp to receive its first day of issue from the capital cities of every state of the United States, and be it further

RESOLVED, that duplicate originals of this resolution, bearing the seal of the State Medical Society of Wisconsin, be sent to the Governor of Wisconsin, the United States Senators and Representatives from Wisconsin, the Postmaster General and the President of the United States, and the President, President-elect, and Executive Vice President of the American Medical Association;

And that facsimiles be sent to the American Medical Association delegates and alternate delegates of each state medical society, the insurance industry, the American Automobile Association, the National Safety Council and others interested in the prevention of traffic accidents—all with the express hope that they will join this nationwide effort to use stamps as a means of delivering a daily reminder to the American people on the necessity of safe driving for longer, healthier living.

14. Presidential Citation for Public Health Achievement

On motion of Doctors Conway–Fox, carried, the Council approved an Executive Committee recommendation that there be created a Presidential Citation to be awarded annually if warranted, to nonphysicians nominated by the President with unanimous approval of the Council.

15. Basic Science Law

For some period of time the Council and its Executive Committee have directed studies of the Basic Science Law. This is the first such law in the country and was enacted under Medical Society sponsorship. The late Dr. A. B. C. Bock of Sheboygan conceived the law as protection for the public health against the uneducated. Examination of the law

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brought out the fact that the overwhelming number of certificates granted on reciprocity were to holders of the Iowa Basic Science certificate. Upon examination of the Iowa law, with approval of the Council it was suggested to the Basic Science Board that reciprocity with Iowa be revoked on the ground that the Iowa law was not comparable in its requirements to those of the Wisconsin law. Whether any definitive action has been taken by the Board since submission of the material in March, 1958, was unknown to the staff.

These further improvements in the law had been discussed with the Basic Science Board:

a. Adding bacteriology and chemistry to the current subjects of anatomy, pathology, physical diagnosis and physiology, thus enabling Wisconsin to enjoy greater reciprocal privileges with other states and giving added assurance of the competence of those passing the Basic Science Board.
b. Increasing the examination fee from $10 to $25 for nonresidents, thus discouraging individuals other than medical students who appear to be taking the Wisconsin examination under the idea that it is less stringent, and then seek reciprocity in their home state.
c. Limiting the number of times an applicant may take repeat examinations in event of failure. The Basic Science Board members themselves recommend that if an applicant has failed one or more subjects three times, possibly four, he should be ineligible for further examination in this state.

On motion of Doctors Conway–Bernhart, carried, the recommendations were accepted and referred to the Committee on Public Policy for appropriate implementation, either at this or a subsequent session of the Legislature.

The Council then recessed from 5:30 until 7:30 p.m.

16. Bill 133, A.

A copy of the hearing on this chiropractic bill had recently been mailed to councilors, officers and others. Its current status was reported, and councilors were asked to urge personal contact by their constituents with legislators.

On motion of Doctors Ekblad–Bernhart, carried, the Council recorded its commendation of the physicians who appeared at the hearing.

17. Keogh–Simpson Legislation

Mr. Murphy reported that should this federal legislation be enacted by the 86th Congress, it may be necessary to ask the Wisconsin Legislature to amend the trust statutes to bring consistency. This would undoubtedly be done in cooperation with the State Bar of Wisconsin, the Bankers Association and others.

On motion of Doctors Bell–Kief, carried, the Council authorized support of such legislation as may be found necessary for this purpose.

18. Elections

a. Chairman of the Council: Doctors James C. Fox and E. L. Bernhart were nominated; Doctor Fox elected by ballot to succeed Doctor Arveson.
b. Treasurer of the Society: On motion of Doctors Dessloch–Lokvam, carried, Dr. F. L. Weston was re-elected.
c. Assistant Treasurers: On separate motion duly made, seconded and carried, Doctors H. Kent Tenney and N. A. Hill were re-elected.
d. Editorial Director, *Wisconsin Medical Journal:* Doctor Conway informed the Council that Dr. J. M. Sullivan did not wish re-election. Doctors D. N. Goldstein and M. F. Huth were nominated; Doctor Goldstein elected by ballot to succeed Doctor Sullivan.
e. Secretary of the Society and of the Council: On motion of Doctors Dessloch–James, carried, Mr. C. H. Crownhart was re-elected.

On motion of Doctor Bell, variously seconded and carried, Doctor Arveson was commended for his work and named chairman emeritus of the Council.

19. Resolution to Dexter H. Witte, M.D.

On motion of Doctors Dessloch–Bernhart, unanimously carried, the Council adopted a resolution of appreciation for the accomplishments of Doctor Witte as a "true medical statesman."

The Council recessed at 9:10 p.m. until Sunday, March 1, at 9:50 a.m., Doctor Fox presiding.

20. 1959 Budget and Finance Committee Recommendations

The Finance Committee recommended a total budget for the State Medical Society of $351,525. Society income from dues and other sources was estimated at $362,150. The Council reviewed each budgeted account and approved the operating budget as presented at $182,350; staff travel expense at $11,250; payroll and associated expense (insurance, social security, etc.) at $157,925. No changes in executive salaries were requested.

Other matters presented by the Finance Committee:

a. Mural on Medical History. Donations totaling $1,075 have been received for the project of a special mural on medical history, primarily in Wisconsin, which is to be placed on the south wall of the Council room in the Society home. The committee recommended that this account be transferred from the Society general funds to the account of the Foundation for its sponsorship.
b. Investment Policy. The current investment policy generally applied is exclusively in U. S. securities and in savings and loans up to the guarantee of the government. It was reported that discussions were under way with an investment counselling service, and until this or some other group has been retained, the com-

mittee recommended continuance of the present investment policy.

c. *Wisconsin Medical Journal* Reserve Funds
The committee recommended that $30,000 of *Journal* reserves, accumulated through current financial success of its operation, be transferred to the Foundation. Of the total, $7,500 would be placed under direction of the Council on Scientific Work in its plans to re-motivate local scientific programs at the district and county level. The balance would be directed to the trustees under condition that it not be expended, but that income from the principal be used to assist the Foundation in its administrative expenses.

d. Pension Plan and Personnel Policy on Insurance. The Finance Committee reported that meeting as trustees of the employees' pension plan in January, it had recorded the eligibility of four additional employees. In addition, the trustees confirmed the Secretary's interpretation of the plan in that a penalty is always applied upon an employee's own termination of employment. Due to misinterpretation, some were of the opinion that after an employee had been under the program for five years, no penalty provision thereafter applied.

The committee recommended approval of the Secretary's proposal that the employees' insurance programs be re-evaluated annually, since more frequent improvement is administratively impractical.

e. Administrative Costs of Student Loan Activities. Prior action had been taken by the Council that administrative costs of providing medical student loans be carried by the Society so that contributions would be used exclusively for loans. This action related to the original Student Loan Fund established at the suggestion of Dr. H. H. Christofferson, now administered by the Foundation, and the Finance Committee recommended that the Council formally act to include administrative costs as to all medical student loan sources.

f. *Badger Doctor's Wife*. The committee reported its belief that a modest amount of appropriate advertising in the *Badger Doctor's Wife* could be obtained and would offset some, if not most of the expenses of its publication, which are included in Auxiliary expenses underwritten by the Society. It recommended that if approved by officers of the Auxiliary, such advertising be instituted.

On motion of Doctors Dessloch–Conway, carried, the budget and Finance Committee recommendations were adopted.

21. Council Award

Doctor Conway moved that the recipient of the Council Award should not be an active member of the Council at the time it is given. This was seconded by Doctor Bernhart, who offered an amendment, seconded by Doctor Ekblad, to the effect that in the future, nominees for the Award be discussed by the Council in executive session and a secret ballot taken, unanimous vote required. Following discussion, the motion and amendment were carried, and the Secretary's suggestion accepted that past action and mechanisms of the Council Award be reviewed at a subsequent meeting.

On motion of Doctor Dessloch, variously seconded and carried, the unanimous vote of those present was recorded for the 1959 nominee, absent members to be contacted personally.

22. Statement on Ethical Principles

On motion of Doctors Bell–Bernhart, carried, action was laid over on a statement possibly involving ethical principles, which arose from an inquiry received by the Secretary.

23. Special May Meeting of Council

In discussion of the special meeting to be held in the vicinity of West Bend to honor Doctor Heidner, the Council agreed that a dinner meeting be arranged on Saturday evening preceding the annual meeting of the Society; that county society officers of the district and local confreres be included; that physicians be billed $10 for themselves and their wives to help defray the cost; and that Doctor Heidner's close friends in the public be invited as guests of the Society.

24. Two Meetings of House of Delegates Annually

In September, 1958, the Council had submitted its recommendation that there be two meetings of the House of Delegates annually, one to receive progress reports, discharge the duties of election, etc., and the other to be held in various areas of the state as facilities are available, and to be an intensified business session. No action was taken upon this recommendation at the special session of the House.

On motion of Doctors Conway–Lokvam, carried, the Council concluded that the present schedule for the House of Delegates be retained until the annual meeting is transferred to a fall date.

25. Advertising Policy

On motion of Doctors James–Bernhart, carried, the policy was adopted that display-type advertising in the *Wisconsin Medical Journal* is not available for physicians' services, etc.; only the classified section (Physicians' Exchange) may be utilized.

26. Annual Meeting of Council

On motion of Doctors Ekblad–Dessloch, carried, the Council established the last week of February each year as the date for its annual meeting.

27. AMEF

Doctor Heidner's report was held for a subsequent meeting.

28. **Committee to Meet with Milwaukee County**

Discussion of the request of President Hildebrand for Council approval to appointment of a committee to meet with Milwaukee County was undertaken in executive session, after which the Secretary was informed of the adoption of a motion by Doctor Lokvam "that the President be given Council approval to appoint a committee from the Council to meet with a committee of the Milwaukee County Board of Directors to examine and attempt to correct any and all differences between the State Society and Milwaukee County Society."

29. **Adjournment**

The Council adjourned at 12:35 p.m. on Sunday, March 1, 1959.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman of the Council

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service plan.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Occupational Health, A Guide for Medical and Nursing Personnel**—General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
14. **The Income Tax for Wisconsin Physicians**—A brochure, newly revised, containing a review of the state and federal income tax laws as they apply to the physicians of Wisconsin.
15. **The Doctor's Role in Adoptions**—A reprint of three *Wisconsin Medical Journal* articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

THE WISCONSIN MEDICAL JOURNAL

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Surgical Closure of the Incompetent Cervix During Pregnancy: The Modified Shirodkar Operation

By HARRIS A. WEISSE, M. D., F. A. C. O. G.

Plymouth, Wisconsin

DURING THE PAST few years a new clinical entity has appeared in obstetrical textbooks in the United States under the heading of cervical incompetence.[1,2] This condition is associated with late abortion or premature labor. The cause is usually cervical trauma from forceful dilatation as in dilatation and curettage or difficult delivery.

Diagnosis should be suspected when a history is obtained indicating normal pregnancies followed by repeated abortions or premature deliveries characterized by spontaneous rupture of the membranes not associated with cramps, then rapid and complete emptying of the uterine cavity. Diagnosis may be confirmed in the nonpregnant state by cervical canal patency allowing easy and painless insertion of a No. 7 Hegar dilator or by hysterography.[3] In the pregnant state diagnosis is made by finding the cervix effacing and dilating between the 14th and 26th weeks of gestation.

Treatment is directed toward closing the gaping internal os. This can be accomplished in the nonpregnant state by means of the Lash cervical repair operation. During pregnancy the Shirodkar operation or one of its modifications is used. Green–Armytage's modification consists primarily of nonabsorbable (at present he uses ¼ inch nylon tape)[4] suture circumscribing the cervix at the internal os and anchored anteriorly by a shallow bite into the cervix. He allows the cut ends to remain about two inches long for easy identification and removal at 39 weeks. As this precedure is a minor one and can be done under local infiltration anesthesia, he repeats it for future pregnancies.

Case Report

R. M., age 34/M, Grava VII, Para III, one abortion at 2 months 11 years ago, ages 10, 8, and 6 years, and 2 abortions at 4½ and 2 months during the past 3 years. She was first seen on December 6, 1957, for a prenatal examination. Her last menstrual period was September 23, 1957. Examination was essentially normal. Chest x-ray, complete blood count, and urinalysis were normal. Blood type B, Rh positive.

When the patient was next seen on January 6, 1958, the pregnancy was progressing normally, but on February 14, a speculum examination, done because of increased discharge, revealed the cervix to be dilated approximately 2.5 cm. and the membranes bulging through the external os. She was sent to the Plymouth Hospital immediately. The following morning, under light general anesthesia and in Trendelenberg position to reposit membranes, two small transverse mucosal incisions were made anteriorly and posteriorly to the cervix; and with a curved Kelly forceps by blunt dissection a white braided-cotton, umbilical cord tape was placed about the cervix and tied with adequate tension to completely close the internal os. It was felt that less heavy suture material might cut through the soft friable tissues. The ends were cut long and left protruding through the mucosa. The patient was sent home via ambulance on the second postoperative day, told to rest for two weeks and to return to the office for examination (6 mile auto trip) at that time. She was examined a total of 10 times during the next 3½ months

during which time her pregnancy progressed normally, and on June 13 the umbilical tape suture was cut and removed painlessly in the office. Labor commenced on July 1, 1958, and terminated within 1 hour in the spontaneous delivery of a 7 lb. 2½ oz. normal male infant.

Conclusions

Although the problem of incompetent cervix is uncommonly encountered and probably is responsible for a very small percentage of all abortions and premature deliveries, the surgical treatment during pregnancy is rapid, not traumatic, almost bloodless and can be done under infiltration anesthesia.[5] Heavy nonabsorbable suture material should be used to prevent dissolution and as it is not associated with gross tissue reaction may be safely repeated with future pregnancies.[5] Salvage may be 80%.[6]

Plymouth Clinic

ADDENDUM

A 35-year-old patient, Grava III, Para II, whose last pregnancy resulted in a viable 3 pound, 3 ounce infant at 31 weeks, was examined by this writer because of painless vaginal spotting (LMP December 14, 1958) at 5 months. The following morning (May 19, 1959) a modified Shirodkar operation was performed. Premature labor developed on July 1, 1959, necessitating removal of the suture and accompanied by delivery of a 2 pound, 14 ounce infant of approximately 29 weeks gestation. Present weight is 3 pounds, 10 ounces (August 5, 1959) and progress is satisfactory.

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5. Green–Armytage, V. B.: Presentation, Second World Congress Obst. & Gynec., Montreal, Canada, June 1958.
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Toxemia of Pregnancy—Major Points in Management

I. MILD PREECLAMPSIA

A. Recognition of Early Signs
   1. Elevation of blood pressure either systolic or diastolic, 15 mm. above *usual* levels.
   2. Albuminuria.
   3. Water retention—rapid weight gain or edema.
   4. Symptoms—headache.

B. Prompt Measures to Control Signs and Symptoms
   1. Low salt diet.
   2. Diuretics.
   3. Rest insured by phenobarbital grains ½ QID.
   4. Frequent follow-up.

II. SEVERE PREECLAMPSIA AND ECLAMPSIA

A. Recognition of the Gravity of the Illness: The Presence of any one of the Signs or Symptoms Listed
   1. Blood pressure of 160 systolic, 110 diastolic or more.
   2. Albuminuria 3 or 4 plus (5 gm./24 hours or more).
   3. Cerebral or visual disturbances.
   4. Pulmonary edema or cyanosis.

B. Prompt Hospitalization and Energetic Therapy
   1. Bed rest.
   2. Foley catheter for accurate determination of output and albuminuria.
   3. Hypotensive agents when indicated such as:
      20 mg. hydralazine (Apresoline) and 5 mg. cryptenamine (Unitensin) mixed in 500 cc. 20% dextrose in water IV at 20 qtts/minute with physician supervision*
   4. Magnesium sulfate in adequate dosage (8–10 grams deep IM) to control irritability and convulsion.
   5. Delivery at optimal time (abdominal or vaginal as indicated).

* Presented at Maternal Mortality Institutes of the State Medical Society and the Wisconsin State Board of Health at: Racine, January 15, 1959; Sheboygan, January 22, 1959; and Appleton, January 29, 1959.

* For details see: *McCall*, Obstetrics and Gynecology, October 1954.

Observations on the Relationship of Warts and Carcinoma*

By JAMES R. HOON, M. D.

Sheboygan, Wisconsin

IN CANCER SURGERY, clinical surgeons are usually most acutely aware of the limitations of their endeavors. The inadequacy of even most extensive surgery in the face of certain malignant growths is a goad, leading surgeons frequently to examine possibilities offered by other fields in the control of malignancy.

Promising, though filled with conjecture, are the approaches to the problems of cancer made by immunologists and virologists.[1] Duran-Reynals, a leading advocate of the virus theory of cancer, has said, "There is no evidence whatsoever that carcinogenesis has ever been observed in the proven absence of viruses."[2] Duran-Reynals died of cancer in March, 1958.

While the position of viruses in the causation of cancer has certainly not been clearly established, there are now a number of known phenomena indicating that possibility. Viruses have been recognized as an etiologic agent in neoplasms in animals for over 50 years.[1] Late efforts have apparently associated viruses with human leukemias, utilizing ultrathin sectioning and electron microscopy. Certain viruses, indeed, have oncolytic powers, experimental evidence having shown that these viruses may tend to localize in neoplasms and even produce demonstrable damage in neoplastic tumors.[1]

Investigation of the role of viruses in cancer has been most difficult. One of the basic problems concerns present limitations in identification and purification of viruses. Another is the latency of viruses which sometimes produce their disease effect as late as 40 years after apparent infection. There even occurs loss of antigenicity so that some viruses cannot be traced by immunologic means.[1] In considering the problem, a clinical surgeon is usually at a disadvantage in making more than limited observations. He certainly cannot go about transplanting tumors or filtrates in his private and innocent patients.

This paper relates observations on a benign human tumor believed caused by a filterable virus: the common human wart, verruca vulgaris. Confusing the literature, there are many skin tumors included in the term verruca, including some definitely precancerous lesions, and some frank cancers. This presentation is concerned simply with verruca vulgaris.

The common wart offers clinical material in great abundance, but many of its features are still unknown. For example, the incidence of warts in human beings has never been determined.[3] Verruca vulgaris is transmissible, both through implantation of fragments of warts and through cell free filtrates.[4,5] The presence of virus-like particles has been noted in electron microscopy and histochemical study of warts.[6,7] Efforts to classify or differentiate verruca vulgaris from other warts etiologically have met with incomplete success. Some indications are that verruca vulgaris is caused by a virus dissimilar to that causing certain other warts. On the other hand, Waelsch in 1918 demonstrated that verruca vulgaris and condyloma acuminata were caused by the same filterable agent.[8]

But there is another peculiarly fascinating feature of verruca vulgaris: It does not appear to become malignant. (There are rare reports of malignancy developing in or from an apparent verruca vulgaris,[9,10,11] but study of a number of these reports indicates that they do not concern true verruca vulgaris.)

This paucity or absence of malignant change in verrucae is most remarkable in view of the excessive exposure of these lesions to many carcinogenic agents. Verrucae commonly occur on the hands and here are exposed to continual traumatic influences. They have been treated by all branches of medicine from the surgeon to the psychia-

* Presented at the Wisconsin Surgical Society Meeting, September 20, 1958, Land O'Lakes.

trist, most treatments involving agents which have been found carcinogenic. Many carcinogenic chemicals have been used in self-treating warts. A host of proprietary wart remedies, many containing carcinogens or presumed carcinogens, is known. Warts have been attacked by radium, x-ray, surgical excision and electrodesiccation. But despite these carcinogenic influences, brought to bear upon this exceedingly common lesion, verruca vulgaris has not, it appears, been observed to become malignant. Does this indicate a degree of inherent immunity?

There are other observations indicating extraordinary relationships of a variety of verrucae to carcinoma. Monitory verrucous dermatoses have been described in visceral cancer by Gougerot and Duperrat (a case of "verrucous nevi" of the arms and hands in a 64-year-old woman with carcinoma of the pancreas).[12]

They cited other reports of monitory dermatoses associated with visceral cancers and asked "Is there a rapport between the dermatosis and the visceral cancer?" Josserand *et al.* described a case of carcinoma of the breast and "verrucae" of the mammary region.[13] In these reports, however, it was not established histologically that the "warts" were verrucae vulgaris.

Brunschwig *et al.* recorded observations suggesting that the virus of the verrucae vulgaris may on occasion hasten malignant degeneration of benzpyrene warts on rabbits' ears.[14] However, their evidence included only 2 animals in a large group of rabbits and they felt that the animals employed were too few to permit definite conclusions. Incidentally, they failed in efforts to produce warts of rabbits' ears by implanting fragments of human warts in 8 animals (Brunschwig himself was the recipient of an inadvertent wart on his thumb as a result of an intracutaneous inoculation of the wart at this site 90 days after injection).

It has been questioned as to whether or not verrucae vulgaris merit inclusion under "neoplasms" inasmuch as they may spontaneously disappear.[15] However, Everson and Cole have reported the recording of 47 proved incidences of spontaneous regression of malignant tumors observed since 1900.[16] Various reasons for these regressions were given. The writer, too, has found evidence of definite regression in metastatic lesions after the removal of primary lesions in colon cancer in 2 patients who later came to autopsy (R. N., female, age 48, and A. G., male, age 62). Reports of the above nature serve to emphasize the desirability of immunologic study of warts, both in themselves and in relation to their association with malignant changes in the host.

Over a 2-year period, 1956 to 1958, observation by the author in his own practice brings forth another puzzling phase of the relationship of warts to cancer. During this 2-year period examination of patients with carcinoma has revealed that, except for the second case cited below, none had present any verrucae vulgaris. This was established by personal physical examination of each patient as well as direct history-taking concerning warts. Some described warts in early childhood but none since, while many patients claimed to have had no warts known during their lifetime.

The patients examined in this series represent carcinoma patients seen in a general surgical practice in a middle-sized Wisconsin city. They number 75 (including a few patients of associates directly examined by the author). The types of malignancy in these cases are carcinoma of the colon, breast, thyroid, uterus, cervix, and skin, and abdominal Hodgkin's disease. The number is small, especially in view of the inferences to be drawn from this preliminary study.

Considering the immunologic possibilities involved, two cases in the series are of particular interest. One patient (M. L., female, age 61) had warts in childhood but none subsequently; then in November, 1944, there was found a small carcinoma of the cervix proved by biopsy and treated with radium. There have been, on repeated examinations since, no evidences of recurrence of the cervical carcinoma. This patient then developed in 1955, a verruca vulgaris of the hand, which was removed in July, 1955, by electrodesiccation.

Another patient (J. W., female, age 60) who stated her family had many warts in childhood, she noting none on herself, had right radical mastectomy performed September 5, 1953, for scirrhous carcinoma. Examinations every 6 months since that date revealed no evidence of recurrence until Spring, 1958, when, on April 18, 1958, a nodule removed from the fatty tissue of the abdominal wall in the left lower quadrant of the abdomen revealed metastatic carcinoma, similar to that removed from the right breast. At this examination, the patient pre-

sented a small, pale, fresh-appearing verruca vulgaris of the web area of the palm between the thumb and index finger measuring about 2.5 mm. in diameter. This she had not previously noted and concluded it could have been present only in the preceding 2 to 3 weeks. The nature of this hand lesion was established by biopsy removal as a verruca vulgaris. This is the only instance in the observed cases over the past 2 years which proved to have a verruca vulgaris present in the face of existing malignant growth.

It may be inferred that clinical, statistical and laboratory investigations may be justified in considering whether the common human wart, verruca vulgaris, exerts any immunologic antagonism to malignant growth. The author certainly does not wish to imply that, on the evidence presented, the presence of a wart on the thumb will protect an individual from malignant growths. But if there is such an influence, even temporary and of incomplete degree of protection, it should not be neglected for want of a thorough look into the matter.

Young, in 1957, has made a startling collateral finding, suggesting the existence of a delicate immunologic balance between viral warts (condyloma acuminata) in the anorectum and carcinoma of the colon.[17] In 300 patients with verrucae in this region, none had colonic cancer, while warts, on the other hand, were not found in any of 300 patients with such carcinoma, although benign polyp of the rectum or colon was observed in conjunction with warts in 28 patients. Young commented that verrucae probably stimulate some type of immunologic reaction in the anorectum. It is further of interest that Waelsch[8] has previously demonstrated that verrucae vulgaris and condyloma acuminata or viral warts of the anorectum were caused by the same filterable agent.

Conclusion

The reason for the presentation of this paper at this time is that further observations over the next 15 or 20 years in a single practice would not statistically prove any more fruitful than the present observation, and therefore a broader field is required for study. There is evidence, based on entirely insufficient clinical material, that a degree of immunologic antagonism may exist between verrucae vulgaris and malignant growth. If so, can this lead not only to a cancer detection test but to an immunologic aid in prevention of cancer?

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oxygen . . . ITS EFFECTIVE USE BY HOSPITALS AND MDs

a teaching conference for physicians and hospital personnel

Wednesday • Sept. 30

ST. MARY'S HOSPITAL • WAUSAU

The proper use of oxygen by physicians and hospitals will be the basis for a full day's teaching program at St. Mary's Hospital, Wausau, September 30, under the sponsorship of the Charitable, Educational and Scientific Foundation of the State Medical Society in cooperation with the Wisconsin Academy of General Practice. The program will be varied, with the morning session aimed primarily at hospital personnel and physicians who are directly associated with the use of oxygen in hospitals; the afternoon program, while of interest to hospital personnel and physicians alike, will stress the use of oxygen in medical situations. Because of supporting funds through the Linde Company, and its Madison affiliate, Red Arrow Corporation, this program will be provided without registration fee. However, to assist in the preparation for food at the hospital for the noon luncheon, an advance registration is requested. The cost of the luncheon will be $1.00. Reservations should be sent to State Medical Society, Box 1109, Madison 1, Wisconsin, indicating whether or not you plan to attend the luncheon.

The program will provide a maximum of 5 hours of Category I credit for all members of the Wisconsin Academy of General Practice in attendance. If attendance is in the morning only or afternoon only, 4 hours of credit will be given.

PROGRAM

MORNING: *Inhalation Therapy—An Essential Factor in Good Patient Care.* Moderator: MR. JOHN HAINES, Luther Hospital, Eau Claire.

9:00—Registration.

9:25—*Welcome.* SISTER MARY KATHLEEN, S.D.S, Administrator, St. Mary's Hospital, Wausau.

9:30—*Oxygen Therapy from the Administrator's Desk.* MR. C. KIRKHAM, Administrator, Lakeside Methodist Hospital, Rice Lake.

10:00—*The Use and Abuse of Oxygen in Hospitals.* JOHN RANKIN, M.D., Associate Professor of Medicine, University of Wisconsin, Madison.

10:30—*Nasal Catheters, Masks, Face Pieces, Humidification and IPPB.* E. R. LEVINE, M.D., Medical Director, Titus Werner Clinic; Medical Director, Inhalation Therapy Department, Edgewater Hospital, Chicago.

11:00—*Tents, Incubators, Hoods and Croup Tents.* ALBERT H. ANDREWS, JR. M.D., Department of Otolaryngology and Research Laboratory, St. Luke's Hospital, Chicago.

11:30—*The Value of "Preventive" Maintenance of Oxygen Equipment.* MR. RICHARD T. DANKS, Supervising Engineer, Hospital Sisters of the Third Order of St. Francis, Springfield, Illinois.

12:00—Panel Discussion: *The Role of Inhalation Therapy in Hospitals.* Questions and Answers. Moderator: E. R. LEVINE, M.D. Participants: Speakers on the morning program.

12:45—Lunch. View of Exhibits. Exhibits will include most of the currently available equipment.

AFTERNOON: *Inhalation Therapy—A Significant Advance in Medical Therapy.* Moderator: W. G. LOCHER, M.D., St. Mary's Hospital, Wausau.

2:00—*Physiological Basis for Inhalation Therapy.* JOHN RANKIN, M.D.

2:30—*Specific Indications and Techniques.* E. R. LEVINE, M.D.

3:15—Coffee Break. View of Exhibits.

3:45—*Inhalation Therapy in the Treatment of Respiratory Disease in Children and Adults.* ALBERT H. ANDREWS, JR., M.D.

4:30—Panel Discussion: *Evaluation of Current Equipment and Techniques.* Questions and Answers. Moderator: E. R. LEVINE, M.D. Participants: Speakers on the afternoon program. Also MR. RICHARD T. DANKS.

Pathologic and Clinical Observations on Coccidioidomycosis*

By ROBERT W. HUNTINGTON, JR., M. D.
Bakersfield, California

I AM MUCH HONORED and a little scared to be talking to this group about our pet Southwestern endemic disease. I had hesitated a good deal in trying to choose between a narrow topic which would lend itself to detailed analysis, and a broad one of more general interest. Those of you who are familiar with tuberculosis know a good deal about coccidioidomycosis even before you see your first case[1, 2] since parallelisms between the two diseases are numerous and striking. Thus, both produce acute pneumonitis, pleurisy with effusion, subpleural caseocalcific chunks, erythema nodosum, pulmonary cavities, miliary dissemination, psoas and vertebral abscesses, and nonpurulent meningitis. Your direct experience with coccidioidomycosis is no doubt considerable. Yet, after some consideration, I have decided to outline in a very broad and general way, how the disease looks in a hyperendemic area.

In the south end of the Great Valley of California there are few brain-teasing problems in differential diagnosis in which coccidioidomycosis does not need to be considered. We who pride ourselves on our familiarity with it have all committed diagnostic howlers both by failing to think of coccidioidomycosis when we should have, and by accepting it as the explanation where we should not. Such errors have been anatomical as well as clinical. Thus, a few years ago I performed an autopsy on a 4-year-old Mexican who undoubtedly had disseminated coccidioidomycosis in his second year. A large number of rather firm nodular masses were admitted to have a troublesome resemblance to sympathicoblastoma but were classed as hyperplastic coccidioidomycosis in the provisional anatomical diagnosis. Only a note in the gross protocol on their perplexing character saved any face at all when the sections came through as classical sympathicoblastoma.

Coccidioidomycosis should not be overestimated as a killing disease.[3] Thus, in 4,989 autopsies at Kern County General Hospital over a 10-year period (1947–1956, inclusive), 63 deaths were ascribed to coccidioidomycosis and 99 to tuberculosis.[4] Our community has kept up with the times in detection, drug therapy, and surgery of tuberculosis; it is one of the notorious hot spots of coccidioidomycosis; and permission for necropsy has been sought much more zealously in known coccidioidomycosis than in known tuberculosis. Even so, the tuberculous fatalities outnumbered the coccidioidal by a considerable margin.

The racial distribution of fatal and nonfatal coccidioidomycosis and of fatal tuberculosis in this autopsy population, discussed in some detail elsewhere, is summarized in Table 1. Two of the patients listed under nonfatal disseminated coccidioidomycosis had certainly had it two years before death, but after death from malignancy (sympathicoblastoma in one case, carcinoma of the cervix in the other), no definite evidence of the coccidioidal infection could be found at necropsy. In two instances, the coccidioidal lesions found at autopsy, though numerous, active, and potentially lethal, were not the immediate cause of death, which was chronic glomerulonephritis with uremia in one subject and myocardial infarction in the other. In 6 patients the metapulmonary coccidioidal lesions were few, inactive, and clearly not of lethal significance.

The figures for nonlethal localized pulmonary coccidioidomycosis represent only the

* Lecture given in part to the Pathologic Seminar at the University of Wisconsin Medical School and at the Veterans Administration Hospital, Madison, November 10, 1958.

From the laboratories of the Kern County General Hospital, Bakersfield, California, and the Department of Pathology, U.S.C. School of Medicine, Los Angeles, California.

TABLE 1—COCCIDIOIDOMYCOSIS AND TUBERCULOSIS IN A 10-YEAR AUTOPSY SERIES

RACE	Total No. Autopsies	Fatal TBC	NON-FATAL COCCIDIOIDOMYCOSIS					FATAL COCCIDIOIDOMYCOSIS DISSEMINATED							TOTAL FATAL COCC.
			Primary Residual Inactive	Pneu-monitis	Cavity	Dissem.	TOTAL	Pneu-monitis	Localized Cavity	Lung and Meninges Only	Meningitis with Visceral Dissem.	Dissem. Meninges not Exam.	Dissem. without Meningitis	Total Dissem.	Psoas Abscesses	
White	3558	41	37	2	2	5	46	1	0	4	10	1	1	16	(1)	17
Mexican	629	41	2	1	0	1	4	0	0	2	1	1	1	5	(0)	5
Negro	667	13	16	0	2	2	20	1	1	2	15	2	14	33	(6)	35
Filipino	58	3	0	0	0	2	2	0	0	1	2	0	1	4	(1)	4
Other	77	1	0	0	0	0	0	0	0	1 (Amerind)	1	0	0	2	0	2
TOTAL	4989	99	55	3	4	10	72	2	1	10	29	4	17	60	(8)	63

cases in which we were able to establish the diagnosis, and are probably a large underestimate of the actual prevalence of such lesions. Demonstration of organisms in acute coccidioidal pneumonia may be quite difficult. Cavitary lesions in which neither fungi, nor mycobacteria, nor other plausible etiologic agents can be demonstrated, are not uncommon in this area, and subpleural and hilar fibrocaseocalcific lesions without demonstrable etiology are one of the real torments of our autopsy service. It is certainly not unlikely that many of these are coccidioidal, but we are unable to determine which and how many.

It will be noted that neither lethal nor nonlethal coccidioidomycosis appeared particularly common in Mexican subjects. On the other hand this group was particularly vulnerable to tuberculosis. Mycobacteria were readily demonstrated in Mexican subjects dying of tuberculosis; and florid, so-called surgical tuberculosis was not rare in this race even though one would assume, in the absence of evidence to the contrary, that the infecting organism was human rather than bovine. Dr. Claude Babcock,[5] medical director of the County Tuberculosis Sanitarium, informs me that at the present time in this community tuberculosis is largely a Mexican disease. On the other hand, the negro group accounted for more than one-half of the coccidioidal fatalities in the series, while its tuberculosis death rate was not significantly greater than that of the caucasoids. The unfortunate Filipinos appeared quite vulnerable to both diseases.

It will further be noted that coccidioidal psoas abscess, the most common type of massive metapulmonary suppuration, while it was seen in both subjects with and without meningitis, occurred six times in the negro group, once in the Filipino, and only once in the white. Moreover florid dissemination without meningitis, and presumably killing too soon for meningitis to develop, was observed in 14 negroes, 1 Filipino, 1 Mexican, and 1 white subject. Thus, the negroes and Filipinos differed from the whites and Mexicans not only in the percentage of fatal coccidioidomycosis, but also in the relative frequency of florid dissemination and of massive metapulmonary suppuration.

Some notion of the variability of the clinical pattern of coccidioidomycosis can be gleaned from this necessarily cursory review of the autopsy material. However, even a

Table 2—Coccidioidomycosis at Kern County General Hospital, 1947– 1956, Incl.

TYPE OF DISEASE	WHITE	MEXICAN	NEGRO	FILIPINO	OTHER	TOTAL
Pulmonary, local, inactive	41	3	16	0	0	60
Pulmonary, local, active, without cavity	49 (7 with erythema nodosum)	13 (4 with erythema nodosum)	17 (1 with erythema nodosum)	4	3 (1 Korean 2 Porto Rican)	86 (12 with erythema nodosum)
Localized pulmonary cavity	27	1	6	0	0	34
Polyarthritis without obvious pneumonitis	1	1	1	0	0	3
Erythema nodosum without obvious pneumonitis	2	1	0	0	0	3
All nondisseminated disease	120	19	40	4	3 (1 Korean 2 Porto Rican)	186
All disseminated disease	34	12	59	10	4 (3 Chinese 1 Amerind)	119
TOTALS	154	31	99	14	7 (3 Chinese 2 Porto Rican 1 Korean 1 Amerind)	305
HOSPITAL ADMISSIONS July 1951–1957	40,163	11,958	10,142	All others incl. Filipino 752		63,015

pathologist may take note of patients not studied at autopsy. Surgical pathology reports were available in 62 additional patients, while in 108 the diagnosis was established without the aid of gross or microscopic anatomy. Some data for the entire group of 305 patients are summarized in table 2.

Polyarthritis and erythema nodosum are alike considered as systemic allergy and not as actual dissemination. Indeed erythema nodosum is considered to be a good prognostic omen. It is not absolute, however, since there was a history of previous erythema nodosum in at least one of our cases of fatal dissemination studied at autopsy. Whether the apparent scarcity of erythema nodosum in the negro represents actual scarcity or difficulty in recognition is a pertinent question.

Diagnosis

Although this entire discussion is clinicopathologic rather than ecologic-epidemiologic, and hence concerned chiefly with coccidioidomycosis which will demand the attention of a clinician or pathologist, one should not forget that the majority of coccidioidal infections are asymptomatic[2] and are recognized anatomically, if at all, only as fibrocaseocalcific subpleural inactive residua.[6]

Clinical. Among the conditions which not infrequently have to be differentiated are tuberculosis, staphylococcus, and other bacterial infections, rheumatic fever, viral pneumonitis, and neoplasm. Numerous rather indolent superficial and deep abscesses, plus hyperplastic granulomas of the skin, would perhaps strongly suggest disseminated coccidioidomycosis even in the absence of confirmatory laboratory data. The writer regrets that his own clinical experience with bovine tubercle bacillus infection in the human is nil, and he is left to wonder how often such an infection could produce a comparable picture in the human. In the past something resembling this has been seen with staphylococcal sepsis, and if the staphylococci continue their resurgence against antibiotics, we may have to anticipate such a thing again in the future. In any case, such a "classic" and "typical" clinical picture of disseminated coccidioidomycosis is so readily confirmed by wet mount and culture of aspirated pus, by biopsy, and by complement fixation that there is no excuse for omitting such laboratory confirmation. The majority of cases of disseminated coccidioidomycosis are not "classic and typical." In fact, the diagnosis was missed prior to autopsy in eight of our own fatal cases.[4] The safe rule, perhaps, is to consider disseminated coccidioidomycosis in anyone from three weeks to extreme old age with any odd illness particularly if febrile. Only in such a way might the illness (for example) of a colored child in the hospital convalescing from severe burns have been recognized. Coccidioidomycosis and other major diseases are not mutually exclusive. Thus, we have seen coccidioidomycosis and Hodgkin's disease and coccidioidomyco-

sis and carcinoma, and the coexistence of coccidioidomycosis and tuberculosis can become very perplexing indeed.[7]

Coccidioidal meningitis can be quite as low-grade and confusing as tuberculous meningitis, and perhaps even more so. Metapulmonary foci in bones and joints may occur with a scarcity of other evidence of dissemination. However, I believe I have seen no fewer errors from interpreting lesions of the extremities as coccidioidomycosis when they actually were tumors than from misinterpretation in the other direction. Coccidioidal pericarditis occasionally raises fascinating diagnostic problems.[8] Miliary coccidioidal nodules are an occasional surprise in surgical tissue from the thyroid to the prostate inclusive. We have had one case of coccidioidal retropharyngeal abscess. Coccidioides occasionally turns up in lymph node biopsies. I don't recall seeing it in tonsillectomy specimens, although we have sectioned a large number.

Some of our radiologists used to feel that the x-ray film of a "thin-walled" cavity was strongly suggestive of coccidioidomycosis. Such an assertion would certainly be questioned in the light of current awareness of tuberculous cavities detectable only on planigrams. Like tuberculous cavities, coccidioidal cavities may be associated with massive expectoration and hemoptysis, or they may be clinically silent. The writer is not aware of substantial clinical criteria for consistent distinction between coccidioidal cavitation on the one hand and tuberculous cavitation, bronchiectasis, or pulmonary suppuration on the other. Laboratory data are required for such distinction.

Similarly, a mere pathologist is unaware of any good anamnestic, percussive, auscultatory, or radiographic means of distinguishing coccidioidal pneumonitis from pneumonitis due to M. tuberculosis, other bacteria, or viruses. A coccidioidal coin lesion has nothing to distinguish it from a neoplastic or tuberculous coin lesion. We have had two cases of coexistent bronchogenic carcinoma and coccidioidomycosis which appear starkly insoluble short of thoracotomy.[9]

Histopathology. The histopathology of coccidioidomycosis has been discussed in some detail elsewhere.[6] We hope before long to achieve further analysis of our material. If a section of a coccidioidal lesion is diagnostic, the diagnosis is based on the demonstration of organisms not on the pattern of host tissue and cellular response. "Typical" mature sporgangia in tissue sections can be recognized with entire confidence by an experienced observer. Characteristic immature spherules can likewise be recognized with substantial assurance. They may be distinguished from calcospheres, if necessary, with the aid of the Schiff-periodic acid stain. There is increasing awareness that, in pulmonary cavities at least, the mycelial phase of C. immitis is not rare.[10, 11, 12] Further study will be required to determine its recognizability from appearance in section. In most active disseminated lesions spherules will readily be found. While in active disseminated disease pus or tissue showing organisms on direct microscopy will consistently yield growth on culture, in localized active pulmonary disease, both cavitary and noncavitary, the results of cultures are somewhat unpredictable, and with inactive pulmonary residua cultures have been consistently negative even when organisms are numerous and typical on wet mount or tissue section. Such recognition of apparently nonviable organisms is in most instances our only means of recognizing the coccidioidal etiology of these lesions. Failure to find organisms most emphatically does not rule out such an etiology.

Microabscesses with epithelioid cell borders may be considered somewhat suggestive of coccidioidomycosis and should give one encouragement to continue the search for organisms. However, such a pattern is surely not unknown in tuberculosis. A coccidioidal pneumonia, like a tuberculous pneumonia, may be largely caseous, largely epithelioid, or largely polymorphonuclear.[6] Miliary disseminated coccidioidal lesions may be epithelioid, caseous, or polymorphonuclear. It has been suggested that a residual "burnt out" subpleural coccidioidal lesion is "not truly granulomatous, merely caseous material surrounded by fibrous tissue."

The writer is unable to visualize the distinction in theory or to recognize it in actual sections. The terms "granuloma" and "granulomatous" appear very perturbing to those who attempt to define them with maximum precision. To the rest of us they remain convenient and useful.

Coccidioides appears to be a good deal more successful as an arid soil organism[13, 14] than as a human pathogen, and better at

invading human lung from the dust than staying there. While dissemination may smoulder along for years, the writer agrees with Smith that if it is to start at all it has to start early in the infection. Such smouldering dissemination is characterized by appearance of new lesions rather than persistence of old ones. One might therefore anticipate that a detailed comparison of coccidioidal and tuberculous lesions might show more polymorphonuclear response in the former. We hope shortly to undertake such a comparison. Even if such a statistical difference could be established, it would not be of much assistance in interpretation of individual cases. A patient not included in this series is a 21-year-old Mexican girl who died at another hospital. In several admissions to this hospital she showed unequivocal evidence of both active tuberculosis and active coccidioidomycosis. Her last admission to our hospital was for spinal cord compression due to an epidural granuloma in which neither mycobacteria nor fungi could be demonstrated. Although after his sad experience with the sympathicoblastoma previously mentioned the writer was inclined to think that while hyperplastic tuberculosis was an established concept, hyperplastic coccidioidomycosis was not, and hence to favor a tuberculous background for this epidural lesion, he was forced to concede his inability to make a definitive differential diagnosis. Unfortunately we have not been able to learn any details of the patient's subsequent course.

The writer, along with Butt[15, 16] and others of what might be termed the California group, has been impressed by the close histologic parallelism between coccidioidomycosis and tuberculosis. Such a parallel has not commended itself to Forbus[17, 18] and the Duke group. Their point of view was ably expressed by Baker[19] in his discussion of the writer's paper at the CDC Conference at Phoenix in February 1957. If the writer had not been fortunate enough to see both a good deal of acute tuberculosis (much of it unmodified by therapy) and a good deal of chronic coccidioidomycosis, he would perhaps have been less convinced of the histologic comparability of the two diseases than he is at the present moment.

Mycology

For direct examination of coccidioidal pus in a bacteriology laboratory, the wet mount with a little sodium hydroxide solution is the most useful technique. Spherules are too large to be handled readily on dried stained smears. The wet mount has diagnostic virtues and limitations comparable to those of fixed tissue sections.

A few unfortunate and widely publicized experiences have, we believe, conveyed an exaggerated notion of the dangerousness of C. immitis cultures. Thus the two technicians who have probably handled more coccidioidal cultures than anyone else continue to have negative skin tests. To be sure, the risks of coccidioidal cultures can be faced with relative equanimity in regions where technicians and everyone else run a much greater risk of infection from dust storms; and our laboratory problem is certainly less difficult than that of laboratories in nonendemic areas. We believe that slants are safer than Petri dishes, that cultures should not be allowed to get too old and dry, and that all reasonable precautions should be used. However, we feel that much further research is needed on the viability of coccidioides at various stages of human infection; that culture is a consistently useful procedure when one can get pus from disseminated disease, and that culture of sputum or excised lung is often the only means of establishing the coccidioidal etiology of pulmonary cavitation. Accordingly we shall continue to do a large number of cultures for C. immitis in our laboratory.

For best cultural results it is important to get plenty of material directly from the lesion and to send it promptly to the laboratory. Thus the practice of sending a dry swab to the laboratory and throwing away a test tube of beautiful aspirated pus is to be deplored. Material not directly from an active lesion is seldom helpful. Thus, serous pleural effusions seldom yield growth. Very rarely indeed coccidioides will turn up in culture of blood or of stomach washing, and when it does, it should be recognized. However, neither procedure is to be recommended as a routine diagnostic measure. A usual experience with spinal fluid cultures in coccidioidal meningitis is to get a single positive at long last after a great many negatives. It is useless to streak just a loopful of spinal fluid. In our experience the best procedure has been to draw as much spinal fluid as possible into a test-tube and then to let that test-tube stand at room temperature for as long as three weeks. The white cottony growth is characteristic, and can be inoculated into animals for final identification.

For routine culture work we have found Saboraud's agar satisfactory, though occasionally growth has been obtained on blood agar when the Saboraud's medium remained sterile. The growth is rather characteristic. In the majority of cultures, wet mounts will show the characteristic rectangular or barrel-shaped arthrospores.[20] In their absence identification can be made through reversion to the spherular phase on mouse or guinea pig inoculation. Finally, our experience has led us to conclude that anything which merits culture for C. immitis should also be cultured for M. tuberculosis, and vice versa.[7]

Skin Tests

Initial skin tests are made with 0.1 cc. of a 1—100 dilution of coccidioidin. If the first test is negative, it should be followed with "second strength" i. e. 0.1 cc. of a 1—10 dilution. Reactions are read at 48 hours, an area of erythema and induration 1 cm. or more in diameter being regarded as positive. Although patients infected with C. immitis sometimes show cross-reactivity to histoplasmin, coccidioidin in these dilutions appears to be relatively specific. A positive skin test therefore may usually be interpreted as evidence of contact with C. immitis. It usually gives very little information as to the activity of the infection or its relevance to any clinical problem. Anyone meriting a coccidioidin deserves a Mantoux also, and a positive coccidioidin has somewhat more definite clinical significance if the tuberculin is negative. Conversion of coccidioidin from negative to positive in association with "flu syndrome" or pneumonitis is substantial though not absolute evidence of the nature of the infection. Doubtless by this means the military services have been able to recognize a number of coccidioidal infections of the kind which we have had to leave as undiagnosed. We used to think that a negative reaction to second strength coccidioidin meant either no infection or an overwhelming one. During severe disseminated disease, a positive to negative conversion is a frequent and ominous sign. However negative second strength skin tests are recorded in six of our patients found to have localized pulmonary coccidioidomycosis.

Serologic Tests. The development of these tests by Smith[21,22,23] is one of the great contributions to modern coccidioidomycology. However, like most laboratory procedures they do not dispense with the need for clinical acumen, and are best interpreted in the light of the whole clinical picture. Strong positive precipitin tests are recorded in 21 patients with acute active localized pneumonitis. Six of these had only negative complement fixations while in five more the titre was only 1:2. The diagnostic value of these precipitin tests seems obvious. In progressive disseminated disease the precipitin usually (though not invariably) becomes negative during the course of months as the complement fixation titre rises. A positive precipitin test suggests early infection; a negative precipitin test does not mean much.

In three instances the diagnosis of disseminated coccidioidomycosis has been made (with some hesitation) on individuals with persistent pneumonitis, high serologic (CF) titre, no identifiable metapulmonary foci. The diagnosis in effect assumes that if biopsies of liver, spleen, or other viscera were available, microscopic evidence of dissemination would be found. Such an assumption is not unreasonable, on the basis of our own and other people's experience. However if such cases were numerous, they would beg the question of complement fixation titre as evidence of disseminated disease. We believe that the diagnosis of dissemination should be made, whenever possible, on the demonstration of metapulmonary foci, and not on serology alone. Of course a group of patients with high CF titres will show a good deal more metapulmonary involvement than a group of otherwise unselected patients with low titres.

Among 88 patients listed under disseminated disease and studied by complement fixation, 53 had complement fixation titres of 1:64 or higher. One should be aware of the prozone phenomenon; patients with massive disease may show weak or negative fixation with 1:16 dilution of serum and strong fixation with higher dilutions. Only one of these 88 patients failed to show positive complement fixation, and a maximum titre of 1:2 was recorded in but 3 more. Conversely, of 21 patients with surgically treated cavities who received CF study, none had titres of 1:64; in 3 the fixation was negative, while in 6 more the maximum titre was 1:2. Of 63 patients listed under localized noncavitary active pneumonitis, none had titres of 1:64 or more, 20 had only negative CF tests,

while in 12 more the highest titre was 1:2. Thus a high or rising complement fixation is ominous, while a low or falling titre is reassuring. A low (1:2) or negative titre is substantial, not absolute evidence against disseminated disease but is quite compatible with local pulmonary activity.

Positive complement fixation in spinal fluid is at least very strongly suggestive of coccidioidal meningitis.[24]

Of a group of 53 cases listed in the hospital files as coccidioidomycosis or probable coccidioidomycosis but omitted from this series after review, 36 were in white patients, 8 in negro, 7 in Mexican, and 2 in Filipino. One case was rejected because of lack of any clinical findings to accompany the persistent high complement fixation titre over a period of three years, while the remainder were excluded for lack of adequate laboratory confirmation of the clinical suspicion of coccidioidomycosis. It is not unlikely, of course, that some, perhaps many, of these actually were coccidioidomycosis cases and a suggestion that in rejecting them the clinical pathologist was overemphasizing his own specialty may merit consideration. All he can say is that he is not convinced that coccidioidal pneumonia can be distinguished from bacterial or viral pneumonias without laboratory data.

It is perhaps usual, in reviewing records, to wish that a good many more things had been done. As a result of this review, we intend to emphasize to our own house staff that in the work-up of any case of suspected coccidioidomycosis the following are essential: Coccidioidin and tuberculin skin tests, with second strength if first strength is negative; precipitin and complement fixation tests, repeated as necessary; whenever spinal fluid is drawn, some of it to be used for complement fixation; adequate cultures of appropriate and available material; prompt delivery of surgical specimens to the pathology department for culture prior to fixation.

Prognosis

For prognostic purposes it is essential to use all available clinical, roentgenologic and serologic aids to distinguish between localized and disseminated disease. Dissemination is frequently associated with persistent massive pneumonitis which may be a major lethal factor. However, although we have ascribed two fatalities to coccidioidal pneumonitis and one to pulmonary cavitation in the absence of gross or microscopic evidence of metapulmonary disease, in general the prognosis of localized pulmonary disease is good, while that of disseminated disease is uncertain.

Although pulmonary cavities do occur in massive pneumonitis with dissemination, the usual coccidioidal cavity is a relatively chronic and stable lesion.[24, 25] We have observed pulmonary and pleural spread from a chronic coccidioidal cavity but have not seen metapulmonary spread. In our only fatality attributed to chronic coccidioidal cavity, death was due to hemorrhage. Intractable hemorrhage is seen in coccidioidal cavities, and constitutes an urgent indication for surgery.

Of the 49 patients with disseminated disease not studied at autopsy, 15 are reported to have died. Of these, 4 had substantial evidence of meningitis prior to death. In 2 of these, organisms were grown from the spinal fluid. Two patients who had meningitis along with evidence of active coccidioidomycosis were living and asymptomatic when last heard from. Proof is lacking that the meningitis was actually coccidioidal, rather than due to some unidentified concurrent infection. Observation at autopsy of very inactive-looking meningitis with hydrocephalus leads to the suspicion that coccidioidal meningitis might arrest spontaneously, or under the rather ineffectual treatments which have been tried. However, coccidioidal meningitis is usually fatal, and long-term arrest of even 2 consecutive cases of coccidioidal meningitis would be rather substantial evidence of the value of a new experimental drug.

In dissemination without meningitis the outlook is much less readily predictable. Our follow-up on these cases is not as complete as we could wish. However 15 patients were alive and relatively asymptomatic on follow-up 18 months or more after the presence of disseminated disease was confirmed. In one of these (a Mexican) the pattern had been one of persistent pulmonary disease with high CF titre without definitely proven metapulmonary focus. In the remaining 14 such foci were demonstrated. One of these patients was Chinese, 2 were Mexican, 3 were white, and 8 negro. Clearly, therefore, the demonstration of disseminated coccidioidomycosis does not call for prognostic de-

spair, nor does apparent recovery need to be uncritically credited to new modes of treatment.

Treatment. The chronicle of the various drugs which have been tried, hailed, and abandoned in the treatment of coccidioidomycosis is instructive if somewhat discouraging.[26] You will perhaps permit the presentation of a dogmatic personal opinion that the only currently available drug worth trying is intravenous amphotericin B. If your lecturer were to develop disseminated coccidioidomycosis he would want that drug. He would not want to have it for anything short of dissemination, for its toxicity is not to be laughed at. Our results, and those of several other groups, appear somewhat encouraging at the moment in patients with metapulmonary abscesses without meningitis. In meningitis the picture remains rather grim. Many of us continue to feel that the real evidence that the right drug has appeared will be recovery in 3, or even 2, consecutive cases of coccidioidal meningitis.

Since we have nothing more specific to offer, it seems prudent to concur in the recommendation[27] of bed rest for acute coccidioidal pneumonitis. Chest surgery should be avoided in this stage unless necessary to evaluate the likelihood of concurrent malignancy.

The problem of surgery in pulmonary cavitation continues to invite debate. Again you will perhaps permit a personal, if not particularly helpful opinion. If possible, surgery in coccidioidal cavity should be delayed until the activity of any surrounding pneumonitis has pretty well subsided. When this stage has been reached—well, there are risks to operating, and risks to not operating. Those who incline to segmental resection with a view to reducing the risks of dissemination are opposed by those equally convinced that such resection increases the risk of dissemination. The writer's personal experience provides little support for either view. He would feel that the decision would have to be made on the behavior of the local lesion. In the presence of massive hemorrhage it will have to be resected. With much expectoration, secondary infection, etc., resection should be considered. My chest-surgeon colleague, Dr. George Paulsen, is now working on this problem and his figures will be awaited with great interest.

Summary and Conclusions

A very broad review has been attempted of the clinical and pathologic problems presented by coccidioidomycosis in a hyperendemic area. It is suggested that the best way to begin thinking about the disease is by comparison with tuberculosis. However, coccidioides, though apparently a rather successful soil organism in the lower Sonoram Life zone, is seen by contrast with M. tuberculosis to be lacking in persistence and adroitness as a human pathogen. Thus, in clinical coccidioidomycosis acute pneumonitis and early dissemination are relatively more important, and chronic cavitary disease less important than in human tuberculosis. Commencement of dissemination after years of successful focalization must be very rare in coccidioidomycosis if it occurs at all. The course of dissemination may be slow and intermittent, and, in the absence of meningitis, recovery is not unusual. Localized pulmonary coccidioidomycosis in the absence of cavitation is a self-limited disease. Chronic coccidioidal cavity is a much less formidable lesion than chronic tuberculous cavity in the era prior to modern drug and resectional therapy.

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(continued on page 494)

Duodenal and Recurrent Ulcer, Surgical Implications, Complications and Mortality: An Analysis of 321 Consecutive Operative Cases*

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BECAUSE OF THE great enthusiasm recently shown by many to accept "new" operations for the treatment of complicated duodenal ulcer, analysis of our surgical experience with this entity was deemed necessary.

The period of study extends from January 1, 1950, to January 1, 1958; 321 operative cases were reviewed. Recurrent ulcers were included as they represent surgical failure to control the ulcer "diathesis". All procedures were performed on the three surgical services of the Veterans Administration Hospital, Wood, Wisconsin. The majority of the procedures were done by the resident staff in the ratio of 4:1. The services concerned agreed on basic principles in the surgical management of duodenal ulcer. Differences included: method of anastomosis, open or closed, types of suture material, the postoperative feeding regimen, and gastric philosophy. Opinion was divided as to whether "individualization" or "standardization" of the operative technique was better.

There were 1,754 patients with duodenal or recurrent ulcer treated during the study period. Of these, 1,700 were primary cases while 54 were recurrent. Two hundred eighty-one (16.5%) of the primary group were treated with definitive surgery; 40 (74.1%) of the 54 recurrent ulcers were subjected to re-operation. Of the group of 281 treated primarily there were 4 (1.4%) known recurrences.

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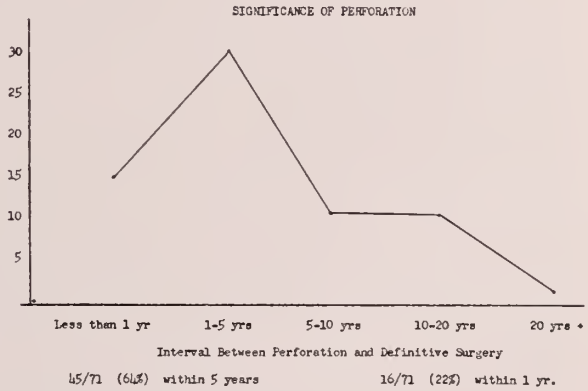
Historical Factors of Significance

Perforation: Perforation is indicative of "virulent ulcer disease".[1] Seventy-one (22.5%) of this group had multiple episodes upon gave a history of perforation. Sixteen (22.5%) of this group had multiple episodes of perforation. Twenty-two (31%) of the patients perforated between age 20 to 30 years; 19 (27%) of the patients perforated between age 40 to 50 years.

Forty-five (64%) of these 71 patients had definitive surgery within 5 years of the initial perforation, 16 (22.1%) within the first year.



The end result of the ulcerative process is obstruction. Thirty-one (44%) of those who perforated had obstruction as the final indication for operation. Seventeen (24%) subsequently bled; 5 in this group required emergency surgery. Fifteen (21%) became intractable while 8 (11%) had re-perforation as the indication for definitive operation.

We still adhere to the principle of simple closure[2] of the perforated ulcer in general. Nonoperative[3, 4] treatment has not been used in any instance. All patients who had perforated were seen early. Interval gastrectomy for perforation has been carried out 10

times, while primary gastrectomy was done in 4 instances.[5,6]

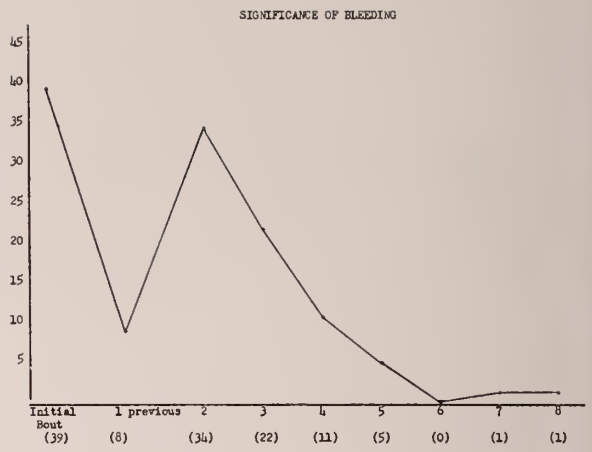
Bleeding: To adequately assess bleeding, definition of massive bleeding and criteria of operability[7] must be set forth as guides. Seventy per cent[7] of these patients with massive bleeding respond to intensive medical management, and interval gastrectomy can be performed within a few days after cessation of bleeding or in 4 to 6 weeks. We prefer the former as we have had 2 patients bleed approximately one month after a previous bout of bleeding. Emergency gastrectomy was performed in both instances.

Fifty per cent of patients with recurrent ulcers had bleeding as the indication for reoperation. Thirty-five per cent had massive bleeding requiring emergency operation. It is usually thought that the bleeding is mild[8] due to inaccessibility of large vessels such as the pancreaticoduodenal artery. We have not been impressed with this thought. We are impressed, however, with the middle colic vessels and their proximity to recurrent ulcers if a retro-colic anastomosis had been done previously. We are also impressed by the location of the ulcer. Formerly it was thought that these ulcers were efferent jejunal; we find that about 40% of them recur as lesser curvature, large gastric ulcers, especially after partial gastrectomy.

Bleeding was the indication for definitive operation in 129 (40.2%) of the total series. Sixty-five (50.4%) of these patients were not controlled by adequate medical management and emergency gastrectomy was carried out. Sixty-four (49.6%) responded to this treatment and interval gastrectomy was performed.

One hundred twenty-one (93.8%) patients had history of bleeding which was reliable. Sixty-nine (57.2%) of the patients in this group were between 50 to 70 years of age. Thirty-nine (32.2%) required emergency operation to control the initial bout of bleeding while 34 (28.1%) needed operative control for the third bout of massive bleeding. Thirty-eight (34.7%) had an ulcer history of 10 to 20 years; 27 had previous surgical procedures to control the ulcer diathesis. Most of these procedures are considered as inadequate in comparing with the now recognized therapy.

Intractability is progressive "virulent ulcer disease," obstruction is the end result.



Analysis of Bleeding Episodes in 121 Patients

These two criteria of operability are usually explanatory.

The Ideal Operation: There is none. The purpose of surgery is that of performing a physiologic maneuver to control ulcer symptomatology and complications. The year 1945[9] marked the change in ulcer surgery. It was shown that a 75% distal gastrectomy was necessary to afford the dog protection against histamine induced ulcer. Intragastric drip experiments showed that the unrugated portion of the stomach along the lesser curvature and the duodenum were susceptible to ulceration. Histotopographic studies showed considerable parietal cell concentration along the lesser curvature to the esophagogastric junction. Clinically and experimentally it was shown that the number of recurrent ulcers approached 50% if there was not an adequate pyloroantrectomy. Demonstration of a gradient of ulcer production from the duodenum to the ileum showed the necessity for a short afferent limb. Further elaboration on this point showed that gastrojejunostomy should be performed within six inches of the duodenojejunal junction because of the marked incidence of ulceration distal to this point. From these studies evolved the "ideal" operation. The components of the standard operation which we employ are: 75% distal gastrectomy, lesser curvature excision, excision of the pylorus and antrum, and a short afferent limb.

We will be glad to accept a lesser procedure when one is proven.

The standard operation is mentioned so

that exceptions can be made on the basis of "individualization." Influencing factors are:

1. *Age.* Individuals under the age of 40 have severe ulcer disease.[10] At least a 75% distal gastrectomy is necessary. The elderly, obstructed patient with low acidity can be adequately taken care of with vagotomy and gastroenterostomy.
2. *Active bleeding.* The purpose of emergency surgery is life-saving. Early control of bleeding[11, 12] and limited gastrectomy, such as a 60% Pólya full lumen antecolic gastrojejunostomy, should be practiced. The ulcer must be excised or at least excluded from the duodenum.
3. *Condition of the duodenum at operation.* The location and size of the ulcer may prompt one to do a two stage resection[13] or the Bancroft modification. A soft pliable duodenum with a small ulcer which can be removed could be suitable for gastroduodenostomy.[14, 15, 16] It may be necessary to do a catheter duodenostomy to facilitate stump closure. Vagotomy and gastroenterostomy may be indicated in the elderly, poor-risk patient with obstruction and marked inflammatory reaction.
4. *Preoperative ideal weight relationship.* If the patient is underweight, it is probably best to do a gastroduodenostomy after the ideal resection or one could do a hemigastrectomy with vagotomy[10,11] and establish continuity with a gastroduodenostomy or gastrojejunostomy.[19] Fat absorption and nitrogen studies[20, 21] show that the gastrojejunostomy is inferior to the gastroduodenostomy in this respect.
5. *The psyche.* Preoperative examination may disclose which patients are potential "dumpers." Lesser resection with gastroduodenostomy could help solve the problem.
6. *Recurrent ulcer.* Vagotomy alone may give relief in 70.5% of patients with a recurrent ulcer if an adequate resection had been previously performed.[8]

   If a vagotomy has not been done previously, it is accomplished. All "hook-ups"' with the jejunum beyond the ligament of Treitz should be taken down and resected or closed as indicated. Resection is accomplished and normal continuity established with an end-to-end gastroduodenostomy. In patients with multiple recurrences, search should be made for ulcerogenic pancreatic adenomas[22] and resection of the body and tail of the pancreas should be done before total gastrectomy becomes necessary.
7. *"Co-existent disease."* "Better a live patient with recurrence than dead without" is often quoted.[23, 24]

   Over 65% of those patients 50 years or older had co-existent disease. Unfortunately these people were massive bleeders whose operation was done under emergency circumstances. Certainly the prime purpose is to stop the bleeding; control of the ulcer diathesis being secondary. Limited gastrectomy is performed for bleeding; vagotomy and gastroenterostomy, or gastroenterostomy alone, may suffice in the elderly patient with co-existent disease.

Types of Operative Procedures

Two hundred seventy-one of the 321 ulcer patients (84%) had either a Pólya or Hofmeister Pólya gastrojejunostomy. Resections were carried out based on the standard operation. "Individualization" was based on the foregoing factors.

Twenty-one (6.5%) had resection according to the standard plan and continuity was established with a Billroth I gastroduodenostomy, end-to-end. Duodenal pathology was minimal to moderate. The patients were thin with ptotic organs. The clamps could be overlayed for one to two inches and not move during the patient's respiratory cycle, to insure anastomosis without tension. We have not employed the Von Haberer Finney end-to-side gastroduodenostomy in any instance.[25] We agree that this operation can be used for 5 to 10% of duodenal pathology and 15% of recurrent ulceration with the "conversion" operation.[26] More recent reports show a high incidence of recurrent ulcer especially if 70% or less of the stomach is resected.[27,28] We have not had any mortality or any serious complications following this procedure.

Ten (3.1%) had re-resection for recurrent ulcer. Vagotomy was performed as a concomitant procedure five times. The jejunum most often was resected; excision of jejunum and transverse closure was also performed.

Seven (2.2%) had vagotomy alone. Most were done for recurrent ulceration. Vagotomy alone as primary treatment gives satisfactory results in 60% of patients,[23,24] 15%

are usually symptomatic, 15 to 25% develop stenosis or recurrent ulceration. The transthoracic approach was utilized once.[29] The completeness of the vagotomy has always been a problem although we have followed a specific technique.[30] Insulin tests were nonconclusive.[31]

Four (1.2%) had vagotomy and gastroenterostomy. It has been reported that the mortality rate is 0.6%, and the recurrent ulcer rate is 6 to 7%.[32]

Vagotomy and partial gastrectomy was performed in 4(1.2%) patients based on acidity studies. All were 75% resections with restoration with gastrojejunostomy.

We do not have experience with vagotomy and hemigastrectomy. Recent reports show that vagotomy and hemigastrectomy is equal to a 70% distal partial gastrectomy; both are superior to vagotomy and gastroenterostomy.[33,34]

Three patients had resection of the jejunum and/or colon. Two had gastrojejunocolic fistulas; one had resection of the jejunum for a jejunal ulcer following gastroenterostomy. The gastrojejunostomy was taken down and no subsequent "hook up" was made.

An elderly, poor-risk patient with obstruction, was treated with gastroenterostomy alone.

Operative Errors

1. Splenectomy incidental to gastrectomy for technical reasons was performed in 15 instances. Eighty per cent were done in patients with active bleeding. Only 4 of these patients escaped complications or mortality.

2. Infarction of the residual gastrocolic ligaments[35] occurred in two instances; omentectomy was performed at the original operation without subsequent incident.

3. Transection of the common bile duct occurred once.

End-to-side choledochoduodenostomy was performed after recognition. There were no unusual postoperative complications. Liver function studies are normal.

The Care of the Duodenal Stump

The only ulcer that has to be removed is one that is actively bleeding; whether this is actual excision with the specimen or exclusion from the duodenum makes little difference. A different story is the post bulbar ulcer where bleeding is controlled with suture ligation with nonabsorbable suture, then gastrectomy is performed. In the latter we may have to deal with the accessory pancreatic duct of Santorini which may open into the ulcer[36] or the papilla of Vater which may be in the vicinity.

The stump was closed with three layers, two of which were absorbable in 85 instances. In 87, two layers were nonabsorbable. Two layer closure was performed 86 times. We have resorted to the McKittrick operation or the Bancroft modification in three instances. We feel these to be difficult closures because of trying to invert into a cone. Catheter duodenostomy was performed 10 times to facilitate stump closure. No concomitant jejunostomies were performed. Drains were employed in 30.5% of the patients.

The "Blown Stump"

The mortality in surgery for duodenal ulcer stems from peritonitis due to dehiscence of the duodenal stump, and to a lesser extent, anastomotic dehiscence.

In 10 (3.6%) patients duodenal stumps blew. Eight of the 10 were drained because of insecure closure. Eight of the blown stumps were in the obstructed, intractable patient. The dehiscence was noted usually from the 4th to 14th postoperative day. It was a relatively minor complication when drains were employed. Routine stump drainage is being practiced elsewhere at present.[37]

Despite the antibiotics the mortality rate with the blown stump in this series was 30%. Three of the "blown stumps" occurred with the McKittrick-Bancroft procedure.

Catheter Duodenostomy

Recent reports[38,39] concerning catheter duodenostomy are encouraging. We have performed 13 during this study period. There were no complementary jejunostomies.[40] Nine of these procedures were performed in the "bleeder" done on an emergency basis.

Catheters were of the Pezzar variety. No. 20–40 F. Fixation was accomplished with purse strings of chromic catgut.

Probably as much duodenal stump closure should have been obtained and the catheter used as a safety valve rather than a bona fide duodenocutaneous fistula. The daily drainage varied from 600 cc. to 3,000 cc., the average being about 1,000 cc./24 hours. The catheters were usually removed in 12 days; several remained for 18 days.

The overall mortality rate with catheter duodenostomy was 38.5%.

The yearly distribution of this procedure is indicative of a "fad." We believe that most stumps can be closed and drainage employed with better results.

When the duodenostomy was done primarily, results were more satisfactory than in the secondary cases such as treatment of the blown stump or when the duodenum is opened to control hemorrhage from a retained ulcer.

Complications

There were 127 complications in 321 consecutive procedures, a complication rate of 39%. Over 50% fell into the category of wound. Abscesses were the majority. There were 16 in the wound proper, 4 in drain sites, and 10 were subphrenic. There were 5 wound hematomas which required opening. Hemolytic *staphylococcus aureus,* coagulase (+) was found in over 50% of the infections.

Dehiscence of the "stump" occurred 12 times; twice in secondary stump procedures, the others were initial. Anastomotic dehiscence occurred 4 times. All developed gastrocutaneous fistulas, one developed a gastrojejuno-bronchial component requiring complete left basilar segmentectomy and diaphragmatic repair for cure. There was dehiscence of the abdominal wound in 8 instances requiring secondary suture. There were three incisional herniae. There was one anastomotic obstruction which was temporary. There were two postoperative perforations; both had x-ray demonstrable pneumoperitoneum. One was treated nonoperatively, the other had a greater curvature perforation. This patient had a concomitant splenectomy.

There were 25 pulmonary cardiovascular complications which were not unusual.

The group of miscellaneous problems proved most interesting. Postoperative hemorrhage[41] occurred 14 times. Only one patient was treated nonoperatively. Review of operative notes revealed that hemostasis was questionable in 80% of instances. Re-operation was usually necessary in 24 to 48 hours. In 8 of the 14 patients bleeding was from the lesser curvature or the anastomosis. The stump and duodenum were incriminated in 4 instances; one patient had bleeding from the stump closure proper, there were also 3 retained ulcers which caused bleeding.[49]

Intra-abdominal hemorrhage occurred twice. The bleeding sites were short gastric and gastroepiploic arteries.

Postoperative jaundice occurred 4 times. One patient had cholangiolitic hepatitis proven by liver biopsy. He also had a chlorpromazine (Thorazine) history.

Staphylococcal enterocolitis[43] is a real problem. Early recognition and vigorous treatment are necessary for survival. The onset can simulate massive atelectasis or even a blown duodenal stump with peritonitis. Six cases were encountered. Pure cultures of hemolytic *staphylococcus aureus* were isolated per stool culture or rectal swab. Chloramphenicol (Chloromycetin) and erythromycin (Ilotycin) were effective initially. Recently there seems to be increased resistance, both in vitro and clinically. Because of this, novobiocin (Albamycin) has been used in cases with a slow response giving dramatic results.

Acute appendicitis and acute cholecystitis[44, 45, 46] were seen as postoperative differential problems. Diagnoses were made correctly. In one patient appendectomy was performed without incident. Another patient with acute cholecystitis was treated conservatively initially and cholecystectomy was performed 6 months later. Cholecystectomy was carried out concomitantly with gastric procedures in 11 instances in this series without increasing complications or mortality.

We have not been troubled with specific types of obstruction due to altered anatomy.[47] Late nonspecific intestinal obstruction was seen in 11 instances. Usually the lower ileum was involved by adhesions or adherent to the incision proper.

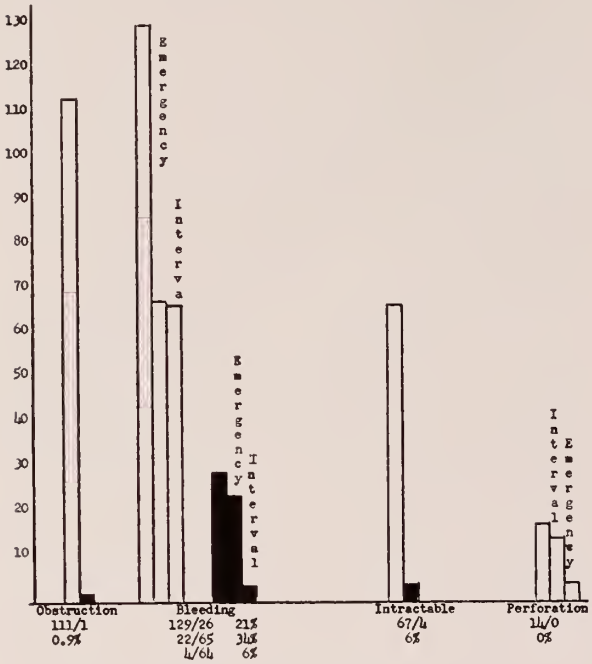
Analysis of Deaths

There were 31 hospital deaths in 321 operative patients. Autopsy data was obtained from 30 of these patients. Some draw conclusions on an autopsy rate of 50%.[42] Twenty-two patients who expired had emergency surgery to control bleeding. Twenty-six of the deaths were in patients whose operative indication was bleeding. We can now see that bleeding means mortality. The mortality rate for interval gastrectomy for bleeding is 6%. The emergency procedure carries a mortality rate of 34% in our hands. To clarify this, there are several factors which must be considered:

1. The large number of patients who have definitive surgery for massive bleeding; 65 of 129 (50.5%).

2. The large number of patients who have bleeding as the operative indication; 129 of 321 (40.1%).

We believe that many of the series with a mortality rate of 1 to 2%[48,49] see primarily the intractable, obstructive group of patients. If we consider this phase, our mortality falls to a respectable 3%.



Let us examine the deaths.

Eight patients died of acute peritonitis.

These included patients with "blown duodenal stump" and peritonitis following catheter duodenostomy. There was an anastomotic dehiscence following jejunal resection, and gastric remnant perforation following incidental splenectomy.

Five patients died of pulmonary complications.

There was a fatal pulmonary embolus in a patient 83 years of age. Prophylactic anticoagulants have not been used. We caution against using leg veins for cutdowns. There were 2 patients with pneumonitis, one patient with atelectasis and one with pulmonary edema.

Four patients died with postoperative bleeding.

One patient died from intraperitoneal hemorrhage from a short gastric artery. A retained ulcer caused fatal hemorrhage on the 6th postoperative day. There was fatal bleeding from a stump closure on the 15th postoperative day. One patient exsanguinated 10 days after performance of a vagotomy for "marginal ulcer."

Three patients died with pancreatitis.

This feature has only been in vogue since resectional surgery has had its upswing.[42] Direct pancreatic and ductal injury must be avoided. Recent reports have called attention to the fact that in 10% of patients the accessory duct of Santorini may be the only functioning pancreatic duct.[49, 50, 51] The orifice of this duct may be within 2.0 to 3.0 cm. of the pylorus. Caution in the dissection of the pancreaticoduodenal symphysis beyond the bifurcation of the gastroduodenal artery has been emphasized. If transection of the accessory duct occurs and is noticed, implantation into the duodenum is feasible.[52]

Three patients died with myocardial infarction.

All of these patients were massive bleeders. Arteriosclerotic heart disease was present preoperatively in all 3 cases. Two patients died in hepatic failure.

One patient was a known cirrhotic. It is known that hypotension associated with bleeding decreases blood flow through the hepatic artery by 60% or more; therefore, liver failure may ensue, especially in one previously damaged.

Six patients died of various causes.

Staphylococcal enterocolitis resulted in one fatality. Other causes of death were: ruptured aortic aneurysm, septicemia due to suppurative prostatitis, cardiac arrest, and chronic pyelonephritis. Perforation of the esophagus following vagotomy also occurred.

Summary

Three hundred twenty-one cases of complicated duodenal and recurrent ulcer have been reviewed.

Perforation indicates "virulent ulcer" disease.[1]

Bleeding presents many problems. Attempts at solution are:

1. Establishment of criteria of operability and definition of massive bleeding.
2. Early control of bleeding, and limited gastrectomy when operation is decided on.
3. Urge earlier operation in the patient with a history of perforation and the patient over 50 with a previous bout of massive bleeding because he is sure to bleed again.

4. It is necessary to remove or exclude the actively bleeding duodenal ulcer. If it is postbulbar in location, suture ligation with nonabsorbable suture may be acceptable if accompanied by gastrectomy.
5. The duodenal stump plays a large part in mortality, despite antibiotics. It is impossible at times to tell which "stumps" will blow. Stump drainage converts a "blown stump" from a major complication to a minor one.

Conclusions

1. Sixty-four per cent of the patients with a previous history of perforation had definitive surgery within 5 years.

2. The elderly bleeder is sure to bleed again. Definitive gastrectomy should be done in anyone over the age of 50 with a substantiated ulcer and a previous bout of massive hemorrhage.

3. Splenectomy done for technical reasons increases morbidity and mortality; 80% of the splenectomies were in patients with active bleeding.

4. The "blown duodenal stump" is a minor complication if drains are employed.

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Iatrogenic Sabotage of Psychotherapy

By CARL L. KLINE, M. D.

Wausau, Wisconsin

A 28-YEAR-OLD WOMAN receiving psychotherapy for a severe anxiety-phobic reaction had been responding well to therapy. Her family physician had referred her originally and a report was sent to him following the initial consultation. One day she appeared for her appointment obviously upset. She promptly burst into tears and related how terribly upset she had been since the previous day. Her family physician had, on that day, while seeing her about another matter, asked her how she was getting along with her psychiatric treatment. She had responded that she was feeling better generally, but still had her symptoms. Whereupon he suggested to her that perhaps she should go to the Mayo Clinic for a checkup. This suggestion was the fuse that ignited her reaction. One week later she was still upset by it.

Why was she so upset? Without going into the details of her story, the reasons, simply stated were: (1) Her doubts about how such symptoms as she had could be caused by "just nerves" were brought to the front again. (2) She thought, "I probably have a fatal disease and they are keeping it from me." (3) She realized that inasmuch as it was a major project for her to get from her house to the psychiatrist's office because of her fears, she could never make the long trip to Mayos. (4) Doubts about her ability to get well assailed her. (5) Distrust in her family physician arose and disturbed her.

Such an incident, and others comparable to it, are frequent occurrences in the practice of a psychotherapist. Why? Physicians do not intend to interfere with their patient's attempts to get well. Things they do or say are usually intended to help the patient become well. How can physicians avoid such pitfalls and how can they best aid their patients who are receiving psychotherapeutic help from a psychiatrist?

First, what are some of the mistakes physicians make in this situation? One of the most common is what might be called the "planting seeds of doubt" technique. This applies to the remarks made by the physician to: (1) Cast doubt on the diagnosis. (2) Cast doubt on the psychiatrist's ability. (3) Cast doubt on the patient's motivation or ability to get well.

Oftentimes the patient in a phase of resistance to her psychotherapy may try to goad the physician into becoming involved in sabotage of her treatment. She may come to him saying, "I've been going to that psychiatrist you sent me to for two months and I'm no better. Don't you think you ought to check me over again? I think it must be something physical." The unwary physician may respond to this, thereby inadvertently casting suspicion on the accuracy of the diagnosis and the validity of the treatment.

Or the patient may say, "Doctor Blank isn't helping me. Why don't you send me to another psychiatrist?" When the physician knows that the psychiatrist whom she is seeing is well qualified and reputable, he should see through this approach quickly and not make the mistake of agreeing with the patient that the psychiatrist is no good. By agreeing with the patient, the physician would, in effect, be casting aspersions on himself.

The "flatter your ego" approach is sometimes used by a patient to goad the physician into conspiring with her to sabotage her own treatment. She may say, "Oh, doctor, why can't I just come to you with my troubles—you have always been so wonderful. This psychiatrist doesn't even talk to me like you do." If the physician agrees to such a proposition, he will soon find himself the target of the patient's hostility.

Another unfortunate mistake made by physicians in relationship to patients in psychotherapy is the "I know all about you" approach. The physician will take the confidential report, written in medical terms to him by the psychiatrist, and read it to the patient. "Yes, sir, you suffer with schizophrenia—a split personality," the physician

might say. The patient goes home or to the library and looks this up. He then goes up to his room and shoots himself.

Patients with emotional illness are nearly all curious about their illness and all too prone to read psychiatric articles and books, usually to their own detriment. This tendency should not be encouraged by the physician. If the patient demands to know about his illness, he should be encouraged to discuss it with the psychiatrist.

Sometimes the physician's sabotage is much less pointed. Such seemingly casual remarks as, "What! Are you still going to that psychiatrist?" or "How are you and the head shrinker getting along?" can be disturbing to the sensitive patient.

One of the most deadly ways in which the physician can interfere with psychotherapy is by becoming involved in the patient's problems himself. This may sometimes be because the physician has formed some kind of attachment to the patient and cannot let go. It can also occur because the patient uses the physician in a dependent fashion to avoid facing her dependency problems in her treatment. She then says, in effect, to the psychiatrist, "I don't need you, I tell all my troubles to Doctor Doe."

Why do physicians do and say such things which are detrimental to their patient's attempt to work out emotional illness in psychotherapy? There are many and varied reasons for this, conscious and unconscious. A few of the outstanding ones will be mentioned here.

Perhaps the most infrequent cause of this kind of sabotage of treatment is open hostility to psychiatry on the part of the physician. Such a physician does not understand psychiatry, knows nothing about it, and does not care to learn. He assumes it is no good, "bunk," "quackery," and other unflattering things. Along with this philosophy usually go such time-worn platitudes as, "It's all your imagination," "There's nothing wrong with you; now forget your symptoms," and "Use will power." Along with such sage advice usually goes some phenobarbital or the latest tranquilizer.

Most transgressions upon the patient's treatment are innocent and therefore done unconsciously. Some physicians have never overcome the sibling rivalry conflict which existed in their own childhood so that other physicians represent the envied and hated sibling. They must, therefore, unconsciously, get even with him by beating him out in competition for the patient's affection and approval.

Another type of physician with a strong unconscious drive for omnipotence and perfection cannot admit that any physician knows more than he does in any area or that any physician can offer better treatment than can he. He may, out of this conflict, try to destroy the treatment being administered by the "rival" physician.

Sometimes a sexual problem exists in the physician to the point where his need for reassurance about his masculinity gets involved in his relationships with his patients, particularly female patients. Their love and "faithfulness" to him are essential and he can not tolerate transfer of "love" to another physician. Such a transfer has the significance of unfaithfulness and, to him, is a threat to his already shaky masculinity.

Not infrequently physicians destroy the treatment before the patient ever gets to the psychiatrist. This is done in the manner in which the initial referral is made. Referrals to the psychiatrist should be made in a positive, open, and constructive way, just as are referrals to any other specialist. Too often the physician apologizes for suggesting that the patient see a psychiatrist. Another negative approach is the deceptive or dishonest maneuver in which the physician tells the patient he is going to send him to a "nerve specialist" or to a "neurologist." Such a revelation of insecurity on the part of the physician is scarcely calculated to instill confidence in the patient.

Physicians are human beings with the same conflicts, defects, faults, and frailties which exist in other human beings. They are therefore subject to making mistakes, often catalyzed by unconscious factors. The conscientious physician readily accepts the fact that he needs to continue to learn. He therefore continues to gain satisfaction through learning and thereby enriches his experiences and his life. All physicians want to help their patients and yet we all sometimes unwittingly do things which are not in the patient's best interest. This paper attempts to indicate some pertinent ways in which a physician can help himself to better help a few of his emotionally ill patients.

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Vaccine Effectiveness in Prevention of Poliomyelitis

By JOSEF PREIZLER, M. D., M. P. H.*

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IN THE HISTORY of man's efforts to control epidemic disease through the use of vaccine, there has been no parallel to the speed with which the effectiveness of any of them has been measured, either as accurately or as well, as that of Salk poliomyelitis vaccine.

This achievement goes beyond the unprecedented, well-planned, massive scale of the 1954 field trials. It embraces epidemiologic, clinical, and research progress prior to these trials, which made possible the subsequent rapid evaluation.

Most of the epidemiology of poliomyelitis is known with a high degree of accuracy because this disease is almost completely reported. Through the cooperation of attending physicians who supply public health officials with detailed information, we have an impressive body of knowledge about the clinical and natural history of the disease, so necessary for ultimate evaluation of vaccine effectiveness.

New techniques of virus identification and serological diagnosis, applied both to clinical cases and mass surveys, make it possible to diagnose poliomyelitis with precision and also to obtain epidemiological information about persons who have inapparent infection. Testing for the safety and antigenic potency of the vaccine can be achieved with great reliability by the use of these newly developed techniques.

The diagnosis of non-paralytic poliomyelitis is very difficult to establish by clinical signs alone. Viral recovery from throat washings or stool and serological tests for rise of antibody titer are definitive aids. Inasmuch as a number of viruses other than polio can cause symptoms of "aseptic meningitis," the evaluation of vaccine effectiveness can be accomplished more accurately by considering paralytic cases only. Even here, some difficulties arise because it is known that some of the viruses mentioned can also cause lower motor neuron and muscle paralysis. Naturally, Salk vaccine offers no protection against these viruses.

Vaccine Effectiveness

A most important fact about the effectiveness of Salk vaccine is that the presence of adequate antibodies in the blood of a vaccinated person will protect him only from paralysis. *A vaccinated individual can be infected with any of the three polio virus types just as readily as a non-vaccinated one and, furthermore, such a person will continue to shed the virus in his stool for as long a period as a non-vaccinated person.*[1] Thus, vaccinated persons can be a source of many new infections: therefore, we cannot hope that, by the use of Salk vaccine, the poliomyelitis virus will disappear from our population as did the smallpox virus through smallpox vaccination.

The Communicable Disease Center of the Public Health Service in Atlanta, Georgia, tabulates and analyzes the detailed reports received from the state health departments.[2] Based on these data for 1958, the following conclusions have been reached:

1. By 1958, it was estimated that 49 million people in the United States were triply vaccinated individuals was 0.19 rate of paralytic polio cases among the triply vaccinated. For that year, the cases per 100,000 vaccinates. The rate of paralytic polio cases among those who received less than three injections, or no injections at all, was 0.71 per 100,000 non-vaccinates for the same year. The ratio between these two rates is 0.27 (27%). This means that for every 100 cases of paralytic polio among non-vaccinates there would have been only 27 such cases had the group been fully vaccinated. It is thus seen that the vaccine is effective in 73% of the cases. Allowing for differences in age specificity, a more conservative over-all

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RECOMMENDATIONS FROM THE SURGEON GENERAL

A bulletin released by Surgeon General Leroy E. Burney on June 24, 1959, makes the following recommendations for vaccination against poliomyelitis with Salk Poliomyelitis Vaccine upon recommendation of a committee of advisors selected from leading authorities in the field of epidemiology and clinical medicine:

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1. Completion of the basic series of three injections of Salk type polio vaccine is recommended for all persons under 40 years of age who have not yet been vaccinated or who have received fewer than three doses of vaccine. Vaccination of persons age 40 and over can also be beneficial; however, it is less urgent since polio occurs less frequently in older individuals. *The recommended basic schedule for all persons, except young infants, is three doses of 1 ml. each as follows:*

   An initial injection
   A second injection 4 to 6 weeks after the first
   A third injection 7 to 12 months after the second dose

2. *A basic schedule of four injections is recommended for infants less than 6 months of age* consisting of a series of three injections of 1 ml. each of polio vaccine, spaced one month apart beginning before six months of age and as early as two months of age, followed by a fourth injection 7 to 12 months after the third dose. Polio vaccine for infants and young children may be given as separate injections or in quadruple vaccines which combine polio vaccine with diphtheria, pertussis and tetanus vaccine. The schedule recommended by the manufacturer of such quadruple vaccines can be followed when this product is used. Infants under 6 months of age do not always develop an adequate antibody response from two initial injections so that the third primary injection appears desirable. Vaccination early in infancy is recommended. However, complete information on optimum dosage schedules will require further experience with the separate and quadruple vaccines.

3. It is recommended that a booster dose of 1 ml. of poliomyelitis vaccine be given to persons under 40 years of age who have completed the basic series of three doses at least 1 year previously and especially if several years have elapsed since completion of the basic series of injections. Such a booster dose is expected to increase antibody titers in persons in whom the antibody levels have fallen or in whom the initial antibody response was weak, thereby providing possible added protection against poliomyelitis.

4. A booster dose of 1 ml. of polio vaccine for vaccinated persons is especially indicated when individuals may be entering situations or traveling into areas where the incidence of polio is high:

   (a) When local epidemics of polio are beginning, an emergency booster dose may be given as early as one month following the previous dose of vaccine regardless of the number of previous doses.
   (b) When preschool children are to enter school.
   (c) Pregnant women prior to the polio season, for the vaccine not only provides added protection against polio for the mother but also provides a passive immunity to the unborn baby.
   (d) Persons traveling into areas where sanitation may be poor or polio is known to be present.

estimate probably would give 70% protection from the use of three polio immunization injections.

2. A comparison of annual paralytic polio incidence-rates for the United States since 1955 shows a constant, steady decrease. It was during this period that more and more people were triply vaccinated. While this trend in incidence may be partially due to normal cyclic variation of the polio epidemics, most of the decrease must be attributed to the success of the vaccination program.

3. The age-specific attack rates in 1958 show a definite drop in children between the ages of 10–11 years. These were the children who participated in the original field trials of 1954 at the ages of 6 and 7. A decrease for these children is noted for each successive year after the field trials.

4. The proportion of paralytic cases occurring in this country, tabulated by number of vaccinations received, shows that as more doses of vaccine were administered, fewer cases with paralysis developed.

Similar conclusions can be drawn from studies of epidemics in Michigan, Texas, and New Jersey.

Reasons for Failure to Achieve 100% Protection

In a recent article in the JAMA[3] Salk suggests that part of the failure to achieve 100% protection is due to "the use of vaccines of less than optimal potency." He also states that "the possible role of the existence of individuals whose immunological mechanisms are unusually poorly responsive cannot be fully evaluated." In his study of blood sera from 2,700 children, Salk found that 28.3% had no complete serological response from vaccination (18.7% no rise against Type 3, 9.1% against Type 1, and 0.5% against Type 2). His vaccine failure data, based on antibody levels, are quite close to those compiled from the reports received by the Communicable Disease Center on paralytic disease in fully vaccinated persons.

Vaccine Safety

Since May 1955, 250 million doses of Salk vaccine have been administered without a single incidence of polio traceable to the use of vaccine. Analysis of cases which occurred within 30 days after vaccination showed no grouping tendency occurring around the 4–11 day period following vaccination. No single vaccine lot was associated with more than three cases, and there was no tendency to develop paralysis first at the site inoculated. (These features were characteristic of the "Cutter" incidence.)

Tonsillectomy Not Recommended in Vaccinated Children During the Poliomyelitis Season

The question of the advisability of performing elective tonsillectomy during the polio season still arises with the practicing physician.[4] Because of this, the recommendation of the Expert Committee on Poliomyelitis of the World Health Organization[5] is cited below:

"Elective tonsillectomies and adenoidectomies have been forbidden in many communities during the poliomyelitis season or during epidemics of poliomyelitis because of evidence indicative of an increased risk of acquiring bulbar poliomyelitis. The mechanism here is believed by some to involve actual contamination of the nerves with poliovirus present in the pharynx. Since immunization with inactive poliovirus vaccine has been found to have no significant effect on the excretion of poliovirus in the stools, it is possible that in vaccinated individuals with low levels of antibody there may also be no interference with multiplication of virus in the pharynx. Accordingly, it was the opinion of the committee that, at least until evidence to the contrary is accumulated, it would be advisable to continue the prohibition of elective tonsillectomies and adenoidectomies during the so-called poliomyelitis season."

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CIRCUIT TEACHING PROGRAMS

OCTOBER AND JANUARY

A series of six teaching programs, consisting of a three-day circuit in October and a second series in January 1960 has been arranged by the SMS Council on Scientific Work in cooperation with the Wisconsin State Board of Health, Wisconsin Academy of General Practice, two medical schools, Wisconsin Heart Association, Wisconsin Anti-Tuberculosis Association, and Wisconsin Division of the American Cancer Society.

FIRST SERIES • OCTOBER		
OCTOBER 13 GREEN BAY St. Vincent's Hospital	OCTOBER 14 ASHLAND Elks Club	OCTOBER 15 WISCONSIN RAPIDS Mead Hotel

SECOND SERIES • JANUARY		
JANUARY 19 VIROQUA Vernon Co. Mem. Hosp.	JANUARY 20 WAUPUN Waupun Memorial Hosp.	JANUARY 21 APPLETON Elks Club

See page 495 for programs of both series

A special feature of the January circuit will be an after-dinner illustrated lecture on "A Physician's Observations in Russia" by Dr. Francis M. Forster, Chairman of the Department of Neurology, University of Wisconsin Medical School, who made a tour of Russia this past year and had the opportunity of visiting a number of medical schools and teachers. Wives of physicians in the areas of the meetings are urged to attend this nonscientific feature of the teaching program.

EACH OF THESE PROGRAMS PROVIDES 4 HOURS OF CATEGORY I CREDIT FOR MEMBERS OF THE WISCONSIN ACADEMY OF GENERAL PRACTICE IN ATTENDANCE

To assist with proper arrangements for the dinner, advance registration is requested. Please use the form below, making your check payable to the State Medical Society of Wisconsin.

RESERVATION FOR CIRCUIT TEACHING PROGRAM: Mail to State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin. FEE (including dinner): $6.00 ($4.00 additional if your wife attends).

I WILL ATTEND THE FOLLOWING CIRCUIT TEACHING PROGRAMS:

		Alone	With Wife For Dinner
Tuesday, Oct. 13, Green Bay: _____	Tuesday, Jan. 19, Viroqua:	_____	_____
Wednesday, Oct. 14, Ashland: _____	Wednesday, Jan. 20, Waupun:	_____	_____
Thursday, Oct. 15, Wisconsin Rapids: _____	Thursday, Jan. 21, Appleton:	_____	_____

NAME: _____ STREET: _____ CITY: _____

Editors
HARRY BECKMAN, M. D., Marquette University
F. E. SHIDEMAN, M. D., University of Wisconsin

COMMENTS ON TREATMENT

Problems in the Therapeutic Use of Adrenal Steroidal Agents

By EDGAR S. GORDON, M. D.*
Madison, Wisconsin

THE STEROID HORMONES have become very helpful and valuable additions to our medical armamentarium, although their use involves a wide variety of complicating problems which have been repeatedly called to the attention of the medical profession ever since cortisone first made its appearance as a practical therapeutic agent in 1949. In the hope of retaining the best therapeutic qualities of these compounds, but at the same time eliminating the most troublesome "side reactions", the steroid chemists, with superb skill, have constantly tried to improve upon nature, by creating artificial steroid compounds with altered biologic and therapeutic potencies. Prednisone, prednisolone, 9α-fluorohydrocortisone, methylprednisolone, triamcinolone, and dexamethasone (Decadron) are representative examples of these new "tailor-made" steroids, each with some special therapeutic attribute which tends to make its use less hazardous. In addition to the qualitative changes in drug action brought about by this chemical tailoring, the new compounds, almost without exception, display enhanced potency on a milligram for milligram basis, as compared to the naturally occurring hormones, cortisone, and hydrocortisone. The result of these two combined improvements is expressed in terms of the smaller dosage of the drug necessary to produce a desirable therapeutic effect. The major complicating side reaction that has thus been circumvented is the abnormal retention of sodium and water, which occurs quite regularly with hydrocortisone when administered in pharmacologic doses.

It is of great importance, however, for physicians to realize that even with these advances given to us by the synthetic steroid chemists, the hazards of employing these drugs in human patients, for the most part, are still present, and are not altered as much as we might be led to believe. One of the major "new" indications for the use of this family of adrenal steroids is to suppress inflammatory and hypersensitivity reactions. For this purpose, pharmacologic doses always are necessary.† Pharmacologic doses of hydrocortisone always produce a Cushing's state if given in large enough dosage and for a long enough period of time. This fact is equally true of all the other steroid compounds belonging to this group, and listed above. Consequently, it is erroneous to believe that the use of a more potent compound, even though a much smaller dose is needed to produce a measurable effect, will obviate the major hazard common to all members of the group, namely, the hyperadrenal cortical state. In this regard, all such drugs must be looked upon as "supercortisones" but still cortisones.

The cause of this phenomenon probably lies in the fact that the capacity to suppress inflammation regardless of its cause, has thus far proved to be inseparable from the metabolic effect upon protein and carbohydrate, which may be defined as a stimulation of gluconeogenesis. This, in turn is identified with the capacity to suppress the production and release of pituitary adrenocorticotrophic

* Professor, Department of Medicine, University of Wisconsin Medical School, Madison.

† Pharmacologic doses are used here to indicate doses in excess of the amounts of hormone secreted under identical conditions by the patient's own adrenal cortex. Physiologic doses, on the other hand, would be, as nearly as possible, identical to the natural output of the adrenal cortex under existing conditions.

hormone (ACTH). Thus, any therapeutic steroid capable of ameliorating the clinical manifestations of rheumatoid arthritis will also induce either the gradual or rapid development of a Cushing's state, dependent upon the magnitude of the pharmacologic dose, and it will also produce effective pituitary inhibition, so that the sudden cessation of treatment will leave the patient in an Addisonian, or more correctly, a hypophysectomized-like state in which the natural defensive reactions to stressful situations will not take place. The principle is equally true of all the steroid compounds in this family of drugs; they differ only in the absolute amounts necessary for daily administration, to induce these effects. It is also true that the undesirable effects are quantitatively parallel to the therapeutic effectiveness, so that no individual compound possesses any special advantage in this regard.

The only exception that must be mentioned concerns electrolyte homeostasis. By means of various chemical tricks, such as the unsaturation of the 1–2 bond in the A ring, the sodium retaining, potassium excreting effect of the natural hormones has been eliminated, so that the occurrence of clinical edema and hypertension as a consequence of treatment has very largely been eliminated. Indeed, some of these drugs actually cause a fairly brisk natriuresis, so that extra dietary sodium should be given with the drug if hyponatremia is to be avoided.

Finally, it should be emphasized that for physiologic replacement therapy, as for example, in Addison's disease or panhypopituitarism, the naturally occurring steroids remain the best therapeutic agents, and their dosage may be calculated upon the normal output of the human adrenal cortex, in the range of 25 to 30 mg. of cortisone equivalent daily, in divided doses. The only noteworthy exception to this general rule is the superb adrenal replacement capacity of 9α-fluorohydrocortisone, which can, in doses of 100 to 300 μg. daily, orally, provide complete substitution therapy for Addison's disease. This is due to the capacity of this compound to provide control of both electrolyte and organic metabolism. Under conditions of stress, extra hydrocortisone may be added to the regimen, and many clinicians prefer to use small supplements for even steady state conditions.

Thus, in summary, it may be reiterated that simply because a drug is more potent, does not necessarily mean that it is better. In the case under discussion, it makes little difference whether a Cushing's state is induced in a patient with 50 mg. of one agent or with 20 mg. of another, when the therapeutic benefit from each is approximately the same. We may all hope that further exploration of this problem may yield additional compounds possessing all of the advantages of our best new synthetic steroids, but finally, with elimination of the danger of inducing the hyperadrenal cortical state with pituitary inactivation, while maintaining all the anti-inflammatory potency of our best current agents. Our present impasse may be resolved in the future, but the personal opinion seems justified that such a development seems, at this time, to be unlikely.

(continued from page 478)

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CIRCUIT TEACHING PROGRAMS

GREEN BAY: Tuesday, Oct. 13
St. Vincent's Hospital

ASHLAND: Wednesday, Oct. 14
Elks Town Club

WISCONSIN RAPIDS: Thursday, Oct. 15
Mead Hotel

Moderator: ROBERT C. PARKIN, M.D. Assistant to the Dean, University of Wisconsin Medical School, Madison

1:30—*Fluid Balance.* DAVID W. SMITH, M.D., Assoc. Prof. of Pediatrics, UW Med. School

2:00—*Plastic Repair of Injury—Primary.* SIDNEY K. WYNN, M.D., Asst. Clin. Prof. of Plastic Surgery, MU School of Med.

2:30—*Gastrointestinal Bleeding.* JOHN LE ROY SIMS, M.D., Prof. of Med., UW Med. School

3:00—*Therapeutic Uses of Blood and Blood Derivatives.* TIBOR J. GREENWALT, M.D., Assoc. Prof. of Med., MU School of Med., and Medical Director, Milwaukee Blood Center.

3:30—Coffee Break

4:00—*Cortisone and Its Analogues—Their Rational Use.* DAVID W. SMITH, M.D.

4:20—*Plastic Repair of Injury—Secondary.* SIDNEY K. WYNN, M.D.

4:40—*The "Nervous" Bowel.* JOHN LE ROY SIMS, M.D.

5:10—*ABO Hemolytic Disease of the Newborn.* TIBOR J. GREENWALT, M.D.

6:15—Dinner

7:30–8:30—Panel Discussion: *Total Care of the Burn Patient in the First 48 Hours.* All afternoon speakers as participants.

The meeting will close at 9:00 p.m. If there is time after the panel, a period of questions and answers will conclude the program.

VIROQUA: Tuesday, Jan. 19
Vernon County Memorial Hospital

WAUPUN: Wednesday, Jan. 20
Waupun Memorial Hospital

APPLETON: Thursday, Jan. 21
Elks Club

Moderator: GEORGE E. COLLENTINE, JR., M.D., Milwaukee

1:30—*Dermatology Clinic.* Review of patients and discussion of cases. DONALD M. RUCH, M.D., Asst. Clin. Prof. of Medicine, MU School of Med.

2:00—*Surgical Management of Intestinal Obstruction.* GEORGE E. COLLENTINE, JR., M.D., Asst. Clin. Prof. of Surgery, MU School of Med.

2:30—*Management of the Convulsive States.* FRANCIS M. FORSTER, M.D., Prof. and Chmn., Dept. of Neurology, UW Med. School.

3:00—Coffee Break

3:30—*Therapy of the Chronic, Draining Ear.* CHARLES R. TABORSKY, M.D., Assoc. Prof. of Surgery (Otology), UW Med. School.

4:00—*What's New in Treatment, and What's Good in What's New.* DONALD M. RUCH, M.D.

4:20—*Recognition and Treatment of Postoperative Complications.* GEORGE E. COLLENTINE, JR., M.D.

4:40—*Treatment of Various Hearing Diseases.* CHARLES R. TABORSKY, M.D.

5:00—Half hour of questions directed to all four speakers.

6:30—Dinner

7:30—*A Physician's Observations in Russia.* FRANCIS M. FORSTER, M.D. (Wives of physicians also invited to the dinner and evening speech).

See page 492 for further details and reservation form

The President's Page . . .

AFTER 129, A. WHAT?

As everyone now knows, after many weary months of deliberation and study, an agreement was reached between the State Medical Society and the Wisconsin Hospital Association which resulted in the passage of an amended version of the highly controversial Bill 129, A. by the Wisconsin Legislature. It will become law when signed by Governor Nelson.

Its effect upon present and future medical practice in hospitals will be substantial. The medical staff of every Wisconsin hospital should become completely familiar with the provisions of the law. If properly observed and enforced, it can be one of medicine's most effective weapons against lay control of medical practice and patient exploitation. The observance and enforcement of the law, as it applies to hospital practices, is the responsibility of each medical staff.

Bill 129, A., as amended and passed, accomplishes these objectives:

1. prohibits fee splitting between physicians, between physician and dentist, chiropodist, optometrist and other paramedical personnel, or between a physician and any corporation or other institution or organization of any kind.
2. provides effective enforcement machinery. In addition to the criminal remedy which, for all practical purposes, could not be and has not been used against hospitals and other corporations violating the fee splitting statutes, the remedy of injunction is also available.
3. recognizes the bona fide partnership or clinic practice of medicine as an exception to fee splitting, and permits the rendition of a single bill for medical services in the name of such a partnership or clinic.
4. permits a hospital—carefully defined and limited—to contract with a physician who may, under such contract, provide consultation services for attending physicians and engage in treatment, but, only at the request of the attending physician—with these important additional safeguards:
   a. such a relationship must have the approval of the hospital's medical staff;
   b. the contracting physician must be a member of or acceptable to the medical staff of the hospital. This provision is intended to provide a continuous check and control against unethical professional conduct such as fee splitting between the contracting physician and the hospital;
   c. prohibits the employment of a physician by a hospital. This with (1) above prohibits the corporate practice of medicine by hospitals.
   d. prohibits a hospital from interfering with the contracting physician's exercise of his professional judgment, and prohibits any supervision or interference with such professional judgment by the hospital;
   e. prohibits the hospital from remunerating the contracting physician on a salary basis, which is considered an evidence of employment;
   f. permits a physician to arrange with the hospital to bill for his services. However, it requires that the hospital bill name the physician rendering medical services and that the hospital bill indicate, where such is the case, that medical charges are included in the hospital charge. This clearly distinguishes hospital from medical services.
5. becomes effective and enforceable on January 1, 1961.

I have only summarized the provisions of Bill 129, A. here. Complete copies are available to you upon request to the State Medical Society.

William B. Hollenbeck, M.D.

"More Lethal Than Gangland Guns"

"More lethal than gangland guns" is the way Mr. John Edgar Hoover characterizes automobiles on the streets and highways of our nation, currently killing in excess of 37,000 persons each year. The blighted, tortured bodies of one and a half million more persons, for some of whom death would have been more merciful, round out the appalling statistics.

The FBI Chief speaks with authority that is unique in America's history; his name is synonymous with law, order, and public safety. The WISCONSIN MEDICAL JOURNAL *is honored to print this month a guest editorial written especially for this publication by Mr. Hoover.*

* * *

There will be scores of deaths on our highways in the days just ahead, yet it is not likely that indictments of the killers will read: "Death caused by a dangerous weapon, to wit, an automobile in the hands of irresponsible persons." But it is a fact that, in careless hands, the sleek metal vehicles flowing in endless streams on the highways of the Nation are proving to be far more lethal than gangland guns.

The carnage on our roads should be the concern of every citizen. It is of direct concern to America's doctors, for while the mangled remains in the mortuary are beyond care, the writhing and mutilated survivors of automotive wrecks become the physician's responsibility.

The weight of that responsibility may be judged from pre-Fourth-of-July estimates of the National Safety Council. The heading of a recent news item read: "350 Slated To Die In Holiday Traffic." The short release revealed that the Council "also estimated 13,000 persons will suffer disabling injuries in highway accidents." Fortunately, a post-holiday release revealed that the actual death toll was substantially less—271 lives lost during a 54-hour period. The news report did not indicate the number who were injured, but on the basis of past experience, one may judge that far more persons were injured than were killed.

What can be done? What can you, the doctors of America, do to halt this mass mutilation and slaughter of which you have such firsthand knowledge?

The medical profession, living up to its fine reputation, already has taken a step beyond its primary responsibility of treating those injured in automotive accidents, and is already at work in the field of accident prevention. The splendid work done by Automotive Crash Injury Research of Cornell University has the support of several major medical groups. On the basis of facts revealed as a result of intensive research within the last decade, the manufacturers of automobiles have been enabled to build vehicles which are, comparatively, much safer than they previously were. The incorporation of safety belts, improved door locks, instrument panel padding, and "recessed hub" steering wheels are among the safety measures resulting in large part from this Cornell research group's studies.

The support which organized medicine has given in this type of work simply does not lend itself to measure. Suffice it to say such support is vital to the continuance of research dedicated to finding ways and means to lower the incidence of deaths and injuries resulting from automobile accidents.

I am convinced that there are four major means to achieving the objective of a reduction in traffic tragedies. These are as follows:

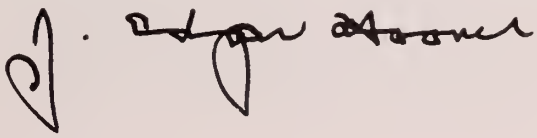
1. Adequate traffic laws.
2. Strict enforcement of such laws.
3. Planning and developing highways and streets calculated to keep accidents to a minimum.
4. Developing proper attitudes through safety education.

The traffic needs of the different communities vary greatly. Certainly, I am in no position to judge the requirements of a particular community. I do know, however, that in areas in which basically sound traffic laws have been subject to strict enforcement, there has been a decline in deaths resulting from traffic accidents.

A study of traffic regulations in different areas might yield most helpful information. For example, the State of New York has a rather unique requirement which, under many circumstances, could be helpful. In accepting a license, the resident of New York signs a statement to the effect that if he refuses to submit to an examination for intoxication, his license is automatically forfeited.

The individual doctor is in a position to do yeoman service in checking citizen slaughter by automobile. The profession of medicine is an honored one. The members of the medical profession are civic leaders. As responsible persons in positions of leadership, individual doctors can do much to force death and destruction off the modern highway by constantly advocating such things as proper driving attitudes, stressing simple courtesy and, emphasizing the need to meet minimum physical requirements as a prerequisite to securing a license to drive.

Civic leadership is essential in determining the traffic needs of a community. It is even more essential in promoting appropriate legislation—and securing public backing—to meet those needs. The individual doctor—the community leader—the man who strives to repair the appalling damage caused by accidents—is in a logical position to pave the way for needful action.



Historic Hydropathy

Just a stone's throw to the east of the State Medical Society building is the old site of the Lakeside Water Cure. Opened in 1855, it was an elaborate spa for its day, but after a few shaky years this medical enterprise went up in flames, literally, when the structure burned.

It was a Sileasian peasant, Vincent Priesnitz, who originated the modern hydropathic or water cure system. Having cured his broken ribs by the cold water treatment about 1829, he publicized his results, and by the 1840's the technique had spread to England and the United States.

Water, it became known, was an extremely versatile and potent substance. In one manner or another it could cure all sorts of ills.

It could be given orally for hiccups, toothache, skin eruptions, palpitation of the heart and fatigue. For gastric hemorrhage the swallowing of ice chunks was recommended.

Water functioned best as a healing agent when it was administered gradually through the skin by the process of "transudation", as it was called. The use of the wet sheet was the generally approved method.

A sheet of cotton or linen, soaked in cold water, was spread on several blankets. The attendant first wound the sheet around the patient, then the blankets, and fastened him in with pins and tapes. Over the enclosed patient was tossed a thick feather bed. And the patient remained in his cold, clammy cacoon anywhere from a half hour to several hours, depending on the seriousness of his condition.

The sopping sheet was useful for reducing all fevers, for toning up the body generally and for whitening the skin of the ladies. If such treatment was impractical or impossible, there was the wet dress. This garment with extra wide sleeves was not, however, as good as the sheet treatment, so there was no guarantee on results. Patients in either case were warned against drinking water.

Most patients, at one time or another, used the water girdle in taking their cure. This consisted of toweling, three yards long, soaked every three hours in the cold water. It was worn for varying periods, and in extreme cases, it was kept on for 24 hours straight. The weak-lunged sufferers also wore a wet jacket above their girdles, and a compress, in addition, was found good for local infections and inflammations.

There were the baths as well. The shower was considered most powerful and seldom advocated. Even the milder douche was to be used with greatest care. The patient was kept in a crouching position throughout, for water falling on the head could be extremely dangerous. However, there was a head-bath which was excellent for treatment of deafness, loss of taste or smell, delirium tremens and inflammation of the brain.

A fine treatment for prolonged insanity was the plunge or cold-air bath. But the most popular of all was the sitz bath. In this metal contrivance the water came up to cover the abdomen, but no further. And only the immersed part of the patient was bare, otherwise he was clothed. With his head, trunk, arms and legs at uncomfortable angles, the patient sitzed not more than 30 minutes as a rule.

The bathers took their cures under varying circumstances: outdoors in natural streams of running water, cascades, and waterfalls or inside in rooms that approached these sylvan surroundings. There were other varieties of baths. One was the towel bath with which the skillful could bathe completely from a single quart of water without messing the carpet. Another employed the dripping sheet and one or more attendants who scrubbed the victim roughly for about five minutes. Sometimes just a sponge was used, and the simplest of all consisted of pouring quantities of cold water over the body.

Although practitioners stated that hydropathy was a little too complicated for home use, in fact most patients continued their treatments at home, using the nearby creek as an endless source of supply.

It is said that some regular doctors added the wet-sheet technique, particularly to treat fevers. Yet other physicians who emphasized the importance of cleanliness in handling their patients were accused of practicing hydropathy.

One good thing came out of the water cure: it helped banish the notion that bathing was immoral, dangerous hygienically and foreign.

TRANSACTIONS OF 1959 REGULAR SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin

MAY 4, 5 and 6, 1959

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FIRST SESSION
Monday, May 4, 1959

The first session of the House of Delegates of the State Medical Society of Wisconsin, held at Hotel Schroeder, Milwaukee, Wisconsin, on May 4, 5 and 6, 1959, convened at 7:45 p.m., Dr. J. D. Leahy, Speaker of the House of Delegates, presiding.

J. D. LEAHY, M.D.
Park Falls

Speaker Leahy (Park Falls): Before we go into the regular meeting, we have Doctor Hirschboeck on our program, and he would like to get away early. We will call on him before we start our meeting.

REMARKS OF DEAN OF MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

Dr. John S. Hirschboeck (Milwaukee): Thank you very much, Mr. Speaker. It is indeed an honor for me to be the first speaker here this evening.

As you know, the Society invites the dean of each of the medical schools to say a few words at each of these meetings. It is always a great treat for me to speak and to convey some of the impressions which we of the medical school in our state gather through the year, and to relate some of our joys and sorrows in operating the two medical schools in the state.

The medical schools of America today are confronted with obligations that are of greater magnitude and diversity than ever before in our history. The need for training more physicians is obvious to all when the single fact of our expanding population is considered. When we add to this the needs that arise from the expansion of medical knowledge and technology, it seems inevitable that more work in the aggregate must be done by the profession.

Greater diversification and specialization among physicians as well as the expansion of services performed by paramedical personnel are phenomena apparent to all. The rapid developments during the last half-century have not kept up with the growth in numbers of the medical profession. Much of our work today is done by members of the 137 or more professional and technical personnel groups now working in the health field. Each of them has sprung, one by one, from the roots and branches of the medical profession. Too many of them have drifted from their father's house and are intellectually and professionally established as independent forces in the field.

It is becoming increasingly difficult for health services to be patient-centered. The unity of approach which was simple 50 years ago, when the family physician could do all that at that time could be done, is now dispersed into the specialties of the profession and the paramedical groups. Our tendency to build higher fences around ourselves has caused poor communication, misunderstanding, high costs, confusion for the public, and dissatisfaction among ourselves and the people. How to bring this all together again in order to provide the best health service is a challenge for the medical schools and universities of our time.

We hear about the study of the whole man, patient-centered teaching, and the team approach. Universities are being asked to reorganize their curricula and even their structure in order to bring about a unity in the roles of the professions.

Research is an equally important function of our medical schools. The Bayne–Jones report recommends that we spend one billion dollars a year for medical research by 1970. It is already obvious to many of us that the trends indicate that this is perhaps a goal for 1965.

How can the medical schools, hobbled as they are by personnel and financial problems, meet this demand? Some of our difficulty is created by a failure of the public to distinguish between what is wanted and what is really needed; and until the expressed wants are harmonized with the demonstrated needs and expressed as one realistic goal, we will continue to have difficulties that handicap the medical schools.

JOHN S.
HIRSCHBOECK, M.D.
Milwaukee

The Marquette University School of Medicine is expanding its personnel and facilities, alone or in cooperation with a variety of private and public agencies and institutions. The remodeling and expansion of our animal quarters in the Cramer Building and the addition of full-time Departments of Psychiatry and Surgery have taken place during the year. We are only beginning to reach our goal.

The financial resources for our operations are diverse and often uncertain. Tuition today is only a small portion of our income. The medical profes-

sion has recognized our needs and is helping to assist the schools as never before. We are particularly grateful to our alumni and the American Medical Education Foundation for all they are doing.

One of the greatest needs of our medical schools is a supply of good students properly motivated toward the old ideals of the profession. Our younger generation is being seduced into other fields of work. The public image of the profession created by forces often beyond our control, but sometimes of our own making, is not what it used to be. The image today is likely to be shaded with shadows of economics and self-serving rather than the clear picture of science and professional service, which it should be.

Unless more superior students enter our schools, the quality of the future profession will deteriorate and our previous independence and leadership will be lost. I encourage you, therefore, to actively solicit the best students you encounter to join our honorable profession.

The Marquette University School of Medicine, I believe, is better off in this respect than some other schools. We do our best to protect the motivation of our students and prompt high ideals. We cannot do this alone. It is the obligation of every physician to be a model for the young candidate to emulate. If all of us strive to show our very best, the results are bound to be good.

Finally, I have a word or two about our present difficulties. It seems that if the objective which is common to all, namely, the will to provide the most efficient, compassionate, economical service of the highest quality available to medical science and art, is constantly before us, we will be on the right road.

It is said that whoever controls the insurance will control the health services. Physicians, hospitals, government, unions, cooperatives, commercial companies or universities are accused by the public and each other of having ulterior motives in gaining control, yet each assures us that their attempts in this direction are for the public good.

I may be naive, or rather ingenious, when I suggest that the best solution to this problem will come when those who provide health services join forces to create a single unified health service corporation, not controlled by the physicians or the hospitals alone, but by both, with substantial support and representation by the consumers. This is not a new idea, but to me it is worth looking at from my ivory tower.

REPORT OF COMMITTEE ON CREDENTIALS

Speaker Leahy: We will now call the meeting to order. First is the report of the Credentials Committee. This committee is composed of Drs. L. H. Lokvam, Kenosha, Chairman; Marvin Wright, Rhinelander, and L. W. Schrank, Waupun. Will the Chairman please report.

Dr. L. H. Lokvam (Kenosha): Mr. Speaker, the Committee on Credentials has verified the registration of 41 delegates and 16 alternate delegates entitled to vote at this session of the House of Delegates.

Also, the Credentials Committee has been informed by the Secretary of The Medical Society of Milwaukee County of the appointment of J. W. Fons, M.D.,

L. H. LOKVAM, M.D.
Kenosha

to act as delegate for that Society in place of the regular delegate and alternate who are unable to attend.

In addition, 9 alternate delegates and 3 Councilors have registered their attendance.

Mr. Speaker, I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 57, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House, to stand for the entire session.

Dr. E. J. Nordby (Madison): Second the motion.

(The motion was put to a vote, and was carried unanimously.)

Speaker Leahy: It might be well to inform the House and the new delegates that this House is a legislative body and its processes are democratic. No delegate should hesitate to present his views. By precedent, discussion has been limited to five minutes for each speaker, but may be extended by permission of the House. Each member is requested to state his full name and the county society he represents when he speaks.

ANNOUNCEMENT OF REFERENCE COMMITTEE APPOINTMENTS

I would like to announce reference committee appointments at this time. I have appointed the following reference committees:

Reference Committee on Reports of Officers

R. S. Gearhart, Chairman, Madison

C. J. Picard, Superior

Gordon Schulz, Union Grove

J. G. Beck, Sturgeon Bay

Gorton Ritchie, Milwaukee

Reference Committee on Reports of Standing Committees

R. M. Waldkirch, Chairman, DePere
H. W. Carey, Lancaster
H. M. Templeton, Barron
S. L. Chojnacki, Milwaukee
E. W. Humke, Chilton

Reference Committee on Resolutions and Amendments to the Constitution and Bylaws

E. D. Sorenson, Chairman, Elkhorn
Donald M. Willson, Milwaukee
H. A. Aageson, Oconto
P. H. Gutzler, River Falls
R. W. Mason, Marshfield

MINUTES OF 1958 SESSIONS APPROVED

The entire proceedings of the 1958 regular session of the House were printed in the November 1958 issue of the *Wisconsin Medical Journal.* The entire proceedings of the 1958 Special Session were published as a supplement to the December 1958 issue of the *Wisconsin Medical Journal,* and corrected in the February 1959 issue.

I will now entertain a motion that these records of the proceedings as printed stand approved.

Doctor Norby: I so move.

Dr. C. J. Picard (Superior): I second the motion.

(The motion was put to a vote and was carried unanimously.)

Dr. Donald M. Willson (Milwaukee): Mr. Speaker, a point of order. I wanted to correct one word in the minutes of the special meeting of the House of Delegates. May I ask the Chair for the privilege of changing a single word? The word "vilifications" is not the word I used. It is on the bottom of page 620 of the special session. The word was "machinations", and I would appreciate it if it can be so changed. I don't like the word "vilifications". It is in the next to the last sentence in the left-hand column.

Speaker Leahy: I am sure there will be no objection to making that correction, Doctor Willson. We will have it corrected on the books if someone will make the necessary motion.

Doctor Willson: I so move.

(The motion was duly seconded, was put to a vote, and was carried unanimously.)

STANDING RULES ADOPTED

Speaker Leahy: Standing rules of procedure are stated on page 3 of the House of Delegates Calendar. Is it the pleasure of the House that these rules be adopted as the standing rules of this session?

Doctor Norby: I so move.

(The motion was severally seconded, was put to a vote, and was carried unanimously.)

REPORTS OF OFFICERS

Speaker Leahy: We come next to the reports of officers. Doctor Fox will report as Chairman of the Council.

SUPPLEMENTARY REPORT OF COUNCIL

Dr. James C. Fox (La Crosse): I am indeed honored to be able to make this report to you on my initial visit to the House of Delegates as Chairman of your Council. You have already received or will receive a report of the Council, but at this time I would like to give you a supplementary report.

The Council met on Sunday, May 3, and reports these further matters to the House:

For the information of the House, the Council can report no progress in its efforts to bring about the change to a fall annual meeting date. The present conflict with legislative activities serves to emphasize the desirability of such a change. However, the facilities of the Milwaukee Auditorium and the various hotels remain committed for the latter half of October and the early part of November, and there seems to be no prospect of a change—at least until some time after 1961.

The Keogh–Simpson bill, providing for deferred compensation of self-employed professionals, has been passed by the House of Representatives and is now pending in the United States Senate.

The Council proposes the following petition which, if affirmed by the House, would be signed by each member of this House and forwarded to our Wisconsin senators:

"The undersigned, members of the House of Delegates of the State Medical Society of Wisconsin, as the elected representatives of more than 3,000 Wisconsin physicians, in annual meeting assembled at Milwaukee, Wisconsin, respectfully petition their Senators as follows with reference to HR 10, also known as the Keogh–Simpson bill:

"1. The undersigned, and the practicing physicians whom they represent, are aware of the great privileges of citizenship in this country, and are well aware that with those privileges go corresponding responsibilities, including the payment of taxes.

"2. The payment of personal income taxes falls with particular heaviness upon self-employed professionals, including physicians, because they almost all report on a cash basis, and because many forms of optional spending which are deductible as business expense by nonprofessional personnel are not deductible by the professional self-employed for legal or ethical reasons, or both.

"3. By definition, self-employed professionals, which includes the overwhelming preponderance of practicing physicians, are unable to benefit from plans of deferred compensation as are professional and other personnel in an employed status. As a consequence, self-employed persons, including professionals, must make provision for periods of illness or retirement out of post-tax dollars, whereas those employed, including professional personnel, are permitted to do so out of pre-tax dollars.

"4. It is hoped that the two Senators of Wisconsin will carefully consider the evidence that as many as 7½ million self-employed persons can benefit by the passage of Bill HR 10, including farmers, merchants, and many types of salesmen and brokers in contrast with the assertion sometimes made that the bill is primarily for the benefit of the professions of medicine, dentistry and law, whose self-employed members total about 450,000 persons.

"5. It is also hoped that the two Senators from Wisconsin will look at the full evidence rather than the largely unsupported estimates of the U. S. Treasury as to the federal revenue losses which would temporarily attend the passage of HR 10. Whereas the Federal Treasury estimates the loss at 365 million dollars, and earlier claimed a much greater loss than that figure, economists and tax experts have estimated the annual revenue deferral in the first years following enactment of the bill at 75 million dollars. Attention is invited to the experience in England since enactment of a similar plan three years ago. There the actual effect on revenues has varied between one-tenth and one-sixth of the estimates made by those opposed to the plan. Canada has had substantially the same experience, despite similar predictions when comparable legislation was enacted in 1957.

"6. In response to any assertions that the bill does not provide the same treatment for all taxpayers, we hope you will both note that this has been true since 1942 of the self-employed, in contrast with employed persons. It may also be noted that the Social Security Act has traditionally achieved major changes by enveloping segments of the population at a particular time rather than all of them at one time. As a matter of plain fact, only a small minority of the self-employed, including physicians, will be entitled to receive the maximum benefits of the bill, since they would have to receive a net income of $25,000 or more for 20 years before retirement. Very few self-employed persons have such an income for a 20-year period.

"7. The undersigned, speaking for the more than 3,000 practicing physicians whom they represent, and for themselves, believe that in asking that self-employed persons, including professionals, receive the same income tax treatment as has been accorded for seventeen years to employed professional and other personnel of comparable incomes, they are asking the correction of an obvious and glaring inequity rather than singling themselves out for any special tax treatment or privilege.

"In light of the above considerations, each of the undersigned expresses the hope that the two of you will support Bill HR 10 actively when it reaches the floor of the U. S. Senate."

It was recommended by the Council and passed by the House of Delegates that this petition be signed by all members of the House of Delegates.

Next, the Council announces the following elections to its Commission on State Departments for the ensuing year:

Dr. T. W. Tormey, Jr., Madison, General Chairman, and these Division Chairmen:

Dr. James Nellen, Green Bay, Handicapped Children

Dr. A. M. Hutter, Fond du Lac, Geriatrics

Dr. G. S. Kilkenny, Milwaukee, Maternal and Child Welfare

Dr. E. D. Schwade, Milwaukee, Nervous and Mental Diseases

Dr. H. W. Carey, Lancaster, Public Assistance

Dr. Ray Piaskoski, Wood, Rehabilitation

Dr. Dayton Hinke, Richland Center, Safe Transportation

Dr. L. M. Simonson, Sheboygan, School Health

Dr. H. A. Anderson, Stevens Point, Chest Diseases

Dr. Meyer Fox, Milwaukee, Visual and Hearing Defects

At the clinical meeting of the American Medical Association in December 1958, a report by its Commission on Medical Care Plans on the subject of free choice and the closed panel system was received, and action was deferred at that meeting pending reactions of individual state medical societies. A full copy of this report was mailed to all members of the American Medical Association.

Your Council believes it is inherent to quality medical care that individuals have their free choice of physician, uncamouflaged by the anonymity of closed panel mechanisms. It advises the Wisconsin delegation to the American Medical Association to stand vigorously on this principle.

Consideration was given to the Society membership certificate which has been used without change for a number of years. The Council proposes that a more dignified type of certificate, containing the general purposes of the State Medical Society, be developed and provided all members beginning in 1960.

The Council wishes to report that the Committee authorized by the Council and appointed by the President of the State Medical Society, and a committee appointed by the President of The Medical Society of Milwaukee County, have met to discuss the problems between the two Societies. Future meetings will be held with a view to providing appropriate recommendations for the settlement of these problems as quickly as possible.

The matter of overlapping jurisdiction and responsibility of the several committees concerned with hospital relations and medical education was considered by the Council, which makes the following special report and recommendation:

A Report by the Council on the Matter of Hospital Relations

The past decade in particular has seen such scientific strides as to startle the nonscientific mind, and of such caliber as to broaden the horizon of medical care far beyond what was once considered its acme of perfection.

It has long been a precept of medicine that personal care of the patient as an individual is synonymous with the quality of care. The patient as a human being must not become lost in the impersonality of the institution. Human beings are endowed with a soul granted them by their Creator; and no matter how great the science is, the soul must be held inviolate and of supreme importance.

Yet the science of medicine is increasingly dependent upon the facilities of the hospital. Every reasonable and well-conceived program of patient care must of necessity be threaded diligently and carefully into the pattern of institutional care, without overemphasis or lack of emphasis.

No greater challenge faces the medical profession and those who assist it in serving the health needs of mankind.

Adequately to hold to these principles, and practically to serve the patient with all modern concepts of medicine, demands leadership, foresight, and the ultimate in planning.

To provide appropriate mechanisms to achieve the medical profession's planning, the Council proposes certain changes in the Bylaws of the Society.

Chapter VIII, Sections 6 and 8 of the Constitution and Bylaws, require the composition of Committees on Medical Education and Hospitals and on Hospital Relations. By action of the House of Delegates of many years' standing, there is a further committee, known as the Committee on Coordination of Medical Services, which has had as its function advising of the Society and the University of Wisconsin Medical School relative to the operation of University Hospitals.

It is recommended to the House that Sections 6 and 8 of Chapter VIII be repealed and that the House also repeal its action of more than 25 years' standing, authorizing the Committee on Coordination of Medical Services.

In lieu thereof, the Council recommends that a new Section be established in Chapter VII, providing for a Commission on Hospital Relations and Medical Education.

As nearly as possible, the terms of one-third of the members of the Commission shall expire each year, with each Commission member being appointed for a term of three years, except that initial appointments would be for one, two and three-year terms. The Commission shall consist of —— members, to be appointed by the President, with confirmation by the House of Delegates.

The duties of this Commission shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities. The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

Finally, the Council forwards to the House for its consideration three resolutions requested by the Douglas County Medical Society.

RESOLUTION NO. 6—Resolution of Douglas County Medical Society. Use of County Facilities for Treatment of Tuberculosis:

WHEREAS, newer drugs have led to more ambulatory care of tuberculous patients, and

WHEREAS, existing facilities for the care of tuberculous patients have experienced a decline in patient census, with resulting high operational costs, and

WHEREAS, the majority of institutions have not availed themselves of existing laws, permitting dual use of facilities, and

WHEREAS, many counties are experiencing need for facilities to house aged persons, and

WHEREAS, no voluntary abandonment of partially-used facilities will be accomplished without study, now, therefore, be it

RESOLVED, that the Division on Chest Diseases of the State Medical Society, in cooperation with the Wisconsin State Board of Health and the Wisconsin Legislative Council, study this problem and report to the 1960 House of Delegates.

RESOLUTION NO. 7—Resolution of Douglas County Medical Society. Authority of State Board of Health Regarding Treatment Programs in County Facilities for Treatment of Tuberculosis:

WHEREAS, existing statutes do not provide sufficient authority to the Wisconsin State Board of Health to adequately secure compliance with its recommendations as to health and medical standards in the operation of sanitoria devoted to the care of tuberculous patients, and

WHEREAS, no uniformity of treatment can be attained without clear authority of some official health agency to enforce rules and regulations; therefore, be it

RESOLVED, that the State Medical Society prepare legislation which will clearly place the Wisconsin State Board of Health in a position of authority as to inspection of sanitoria, enforcement of rules regarding treatment as well as facilities, and that funds sufficient to carry out this program be made available through action of the Wisconsin Legislature.

RESOLUTION NO. 8—Resolution of Douglas County Medical Society. Treatment of Tuberculous Patients with Mental and Emotional Problems Needing Psychiatric Care:

WHEREAS, the treatment of tuberculous patients with mental and emotional disorders requires specialized facilities and personnel, and

WHEREAS, it would be most desirable to have such treatment conducted in areas of the state where psychiatric service is most readily available, and

WHEREAS, existing facilities in Madison and Milwaukee are prepared to render this service on a statewide basis; therefore, be it

RESOLVED, that existing facilities at Douglas County Tubercular Sanitarium be closed, and all patients served through this facility be transported to available facilities in the State where proper psychiatric care can be given to the tuberculosis patient afflicted with mental disease.

REPORT OF PRESIDENT

Speaker Leahy: The next report will be the address of the President, Doctor Hildebrand.

[The report of the President, W. B. Hildebrand, Menasha, was published in the June issue of the *Wisconsin Medical Journal.*]

REPORT OF TREASURER

The next report will be that of the Treasurer, Dr. F. L. Weston.

(Treasurer F. L. Weston presented his report as follows:)

Dr. F. L. Weston (Madison): In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit, herewith, my annual report of the state of the Society's funds at December 31, 1958, and the operations of the Society during the year 1958.

F. L. WESTON, M.D.
Madison

This report relates only to those operations of the Society which are the direct responsibility of the Treasurer. Accordingly, it does not include information with respect to financial condition and operations of the *Wisconsin Medical Journal*, Wisconsin Physicians Service, and the Wisconsin Veterans Medical Service Agency. However, the net worth of the *Wisconsin Medical Journal* is included in the Society's net worth in this report. Since reserves of the prepaid plans are held by them for internal purposes, they do not represent any part of the Society's net worth. The Wisconsin Veterans Medical Service Agency, performing solely as an agent, has no excess or deficiency of income related to expense, and therefore, no net worth.

The following Exhibits and Schedule make up this report:

Exhibit A—Financial Statement at December 31, 1958

Schedule A–1—Reconciliation of Net Worth at December 31, 1958

Exhibit B—Statement of Income and Expense —Year Ended December 31, 1958

The records of the State Medical Society of Wisconsin have been audited for the year 1958 by Donald E. Gill and Company, Certified Public Accountants.

Exhibit A

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

FINANCIAL STATEMENT
December 31, 1958

ASSETS		
Cash on Hand and in Banks		$ 48,811.45
(Principally prepaid 1959 membership dues and other 1959 income prepaid)		
Due from Divisions and Related Organizations of the State Medical Society:		
Wisconsin Medical Journal	$ 1,409.58	
Wisconsin Physicians Service	15,145.66	
Wisconsin Veterans Medical Service Agency	1,287.39	
SMS Realty Corporation	1,107.07	
Charitable, Educational, and Scientific Foundation, Inc.	14,440.24	
Total		33,389.94
(Primarily advanced operating expenses)		
Other Accounts Receivable		4,815.49
Working Capital Advances:		
Wisconsin Medical Journal	$ 47,982.16	
Wisconsin Veterans Medical Service Agency	7,500.00	
Total		55,482.16
Guaranty Deposit—Northwest Airlines		425.00
Furniture and Equipment	$ 37,096.85	
Less: Accumulated Depreciation	(25,738.41)	
Fixed Assets—Net Book Value		11,358.44
Prepaid Expenses and Deferred Charges		15,726.39
TOTAL ASSETS		$170,008.87
LIABILITIES		
Vouchers Payable	$ 20,122.68	
Dues—Suspense	383.00	
Accrued Expenses	1,258.53	
Prepaid Membership Dues	21,818.00	
Prepaid Auxiliary Dues	360.00	
Prepaid Annual Meeting Income	6,340.00	
TOTAL LIABILITIES		$ 50,282.21
NET WORTH		
Surplus—General Fund	$ 69,492.66	
Net Worth of Wisconsin Medical Journal	47,982.16	
Surplus Reserved for New Building	1,075.00	
Surplus Reserved for Section on Medical History	1,176.84	
TOTAL NET WORTH		$119,726.66

Schedule A-1

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1958

Net Worth—December 31, 1957		$104,549.02
Additions:		
Excess of 1958 General Fund Income over Expenses	$ 745.88	
Increase in 1958 of Net Worth of Wisconsin Medical Journal	14,431.76	
TOTAL ADDITIONS		$ 15,177.64
Net Worth—December 31, 1958		$119,726.66

1959 SMS ANNUAL MEETING IN PICTURES THROUGHOUT THIS REPORT OF TRANSACTIONS OF THE HOUSE OF DELEGATES

Exhibit B

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1958

INCOME		
Administrative and General Income		
Membership Dues—Current Year	$237,647.75	
Membership Dues—Prior Year	1,613.70	
Total		$239,261.45
Other Income		
Annual Meeting	$ 25,753.39	
Postgraduate Clinics	5,365.66	
Section on Medical History	110.00	
Cafeteria	17,969.75	
Miscellaneous	3,360.22	
Total		52,559.02
TOTAL INCOME		$291,820.47
EXPENSES		
Accounting Services	$ 5,733.94	
Association Dues	1,186.68	
Cafeteria—Food and Supplies	13,121.40	
Conference Expense	34,868.00	
Depreciation	2,759.40	
Grants and Appropriations	500.00	
Insurance—General	923.37	
Insurance—Employees	3,323.59	
Legal Services	13,769.64	
Legislative Retainer	3,450.00	
Miscellaneous Expense	2,185.36	
Office Supplies and Expense	3,675.76	
Outside Services	5,650.31	
Postage and Express	7,532.95	
Printing and Forms	20,575.26	
Promotion	3,878.78	
Property Taxes—Personal Property	386.47	
Rent—Central Office	18,728.00	
Rent—Other	6,025.77	
Rental—Other Equipment	482.61	
Repairs and Maintenance—Equipment	1,397.84	
Resource Material	1,542.25	
Retirement Plan Contributions	3,721.88	
Salaries	123,098.62	
Speakers' Honoraria	3,234.75	
Taxes—Payroll	2,785.58	
Telephone and Telegraph	2,680.77	
Travel Expense	11,634.65	
TOTAL EXPENSES	$298,853.63	
Less: Portions of above expenses charged out for services rendered to others	(7,779.04)	
TOTAL NET EXPENSE		291,074.59
Excess of Income over Expense		$ 745.88

ANNOUNCEMENT OF SECRETARY

Speaker Leahy: Next will be the report of the Secretary, Mr. Crownhart.

Secretary C. H. Crownhart: Mr. Speaker, I should like the consent of the House to provide you with a supplementary report on Wednesday, in light of some current developments about 86 miles west of here.

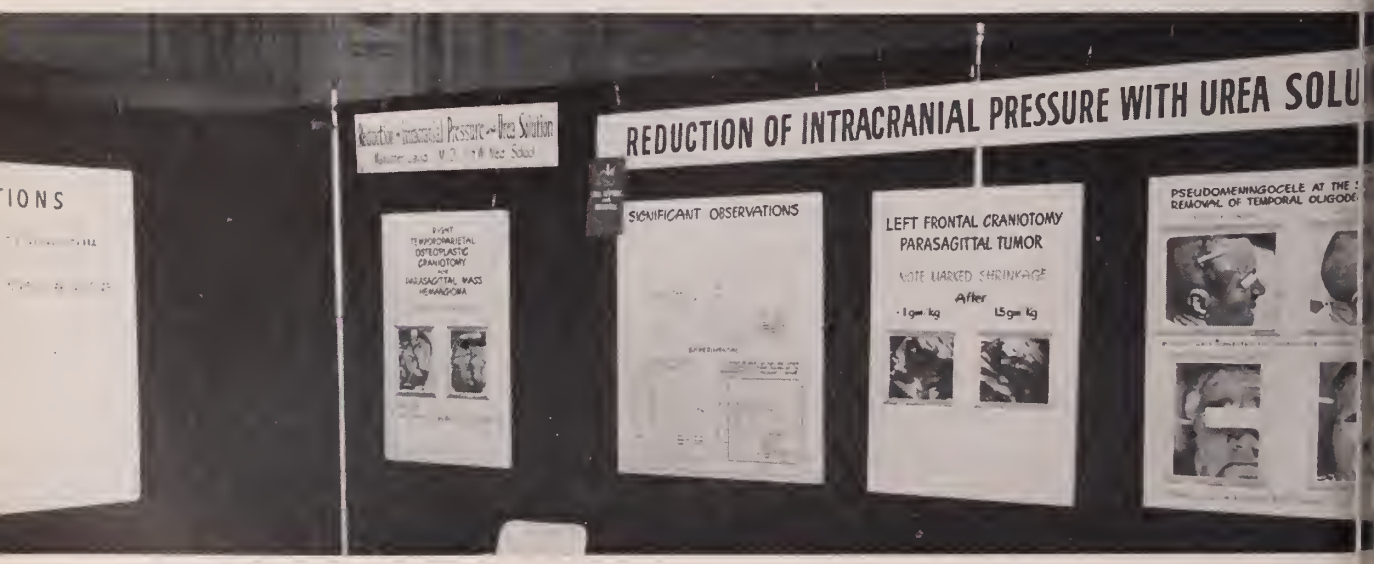
At this time may I merely report to you, in addition to the necrology report of the Council, the deaths of the following doctors:

K. W. Baker, M.D., Turtle Lake
A. M. Blake, M.D., Waunakee
*Joseph Kurtin, M.D., Cudahy
*S. A. McCormick, M.D., Madison
*Louis McBain, M.D., Appleton

* Members of State Medical Society.

Speaker Leahy: Next will be the report of Dr. C. N. Neupert, State Health Officer.

First place winner for individuals in the 1959 SMS Scientific Exhibit at the annual meeting in May was Dr. Manucher Javid, associate professor of surgery, UW Medical School, Madison. His exhibit is shown below. Dr. Sidney K. Wynn, assistant clinical professor of plastic and reconstructive surgery, MU School of Medicine, Milwaukee, was awarded second for his exhibit entitled, "Primary and Secondary Plastic Repair of Injury." The exhibit entitled "Transverse Fetal Presentation," won third place for Dr. Edgar Habeck of Evangelical Deaconess Hospital, Milwaukee.



REMARKS OF STATE HEALTH OFFICER

Dr. C. N. Neupert (Madison): The privilege of appearing before this House of Delegates is highly regarded by the Board and by me, its executive officer. It constitutes a symbol of the fine cooperative relationships we continue to enjoy working together to advance the health of the people we serve. To you, that means patients; to us, communities of individuals.

The privilege carries with it a responsibility as is true of most privileges—that of rendering an account of our stewardship. Very briefly, a few highlights:

Last Thursday, at its April meeting, the Board welcomed a new member, Dr. Edward N. Vig of Viroqua. He succeeded Dr. Carl Neidhold of Appleton, who had served so well for the past nine years.

Doctor Vig had a rough initiation. In the few days prior to the meeting he had virtually reams of transcripts, reports and informational material to read and digest. I hope he was able to slip in a little time to care for his patients during those several days. Every month he will be faced with studying material that comes to him about once a week, getting ready for the monthly Board meeting at which official decisions are made that bear on the advancement of health. Such is the responsibility assumed by each Board member.

When Dr. Steve Gavin, one of the outstanding men of medicine in our state, first came to the Board soon after my appointment over 16 years ago, he expressed surprise at the comprehensive responsibilities he had assumed, and regret that physicians and people generally were not better informed as to the Board's scope of activities and how those activities touched the lives of all, even though for the most part they were not aware of it.

May I stress that over the years the Board has in effect followed the concept of Lincoln as to its role as a governmental agency. He said so well:

> "The legitimate object of government is to do for a community of people whatever they need to have done but cannot do at all or cannot do as well for themselves in their separate and individual capacities. In all that the people can do as well for themselves, the government ought not to interfere."

Our laws enacted by the Legislature govern what activities the Board may engage in, and appropriations of funds to carry them out come up for review and specific action at least every two years. But voluntary or enthusiastic cooperation on the part of physicians cannot be legislated. It must be deserved and extended voluntarily on the basis of conviction that it is in the best public interest.

The law creating the State Board of Health was enacted at the persistent urging of a rural physician with the backing of the State Medical Society back in 1876. Epidemics of diphtheria were among the problems facing physicians and their patients leading to this step. Since then there has been substantial progress resulting in virtual elimination of the chief killers of that day by way of applying the results of scientific research such as immunization, the antibiotics, and so on. Activities in the areas of sanitation, laboratory and communicable disease control become accepted functions of the Board as a governmental agency.

But even within those areas there was a period when survey chest x-rays as a screening procedure for finding early tuberculosis among the apparently well was questioned as possibly being beyond the legitimate role of the State Board of Health. It has become recognized as proper and in the public interest, and has the support of medicine.

With changing conditions come new challenges and needs to be met, such as those incident to an aging population. The leading causes of death and disability are no longer the communicable diseases, but the chronic diseases, with three-fourths of our deaths now due to cardiovascular diseases, cancer, diabetes, and so on.

Screening procedures of the apparently well are emerging. What materializes by way of diagnosis and treatment is dependent on what the family physician does following referral to him of possible leads.

Agreed, some of these leads are nonproductive, but over-all the procedures are finding unsuspected chronic disease among the apparently well in sufficient numbers to justify their use, to the definite benefit of the patient. Further refinements of these techniques can be expected to emerge from extensive research that is in progress.

The plea, then, is to carefully evaluate any new developments in the area of screening as may be proposed by the State Board of Health. There are no new ones currently before it. Any that may come up would be carefully evaluated as to merits and in accordance with the Lincoln concept.

Drs. W. D. Stovall, Madison, William B. Hildebrand, Menasha, L. E. Holmgren, Madison, and Gunnar Gundersen, La Crosse. —Doctor Stovall receives plaque for commemorative entrance to SMS headquarters.

One of the roles of the Board is that of establishing health regulations of statewide application. Among them are those governing maternity hospitals. Significant revisions, some of which were urged by members of this House, are in the process of preparation and should be in force in two or three months.

You have had effective representation on the Advisory Committee which is preparing the revisions. Public hearings and due publication after the Board has acted will take time, but we all agree that the democratic process, whereby the interests of all people are guarded, is necessary though usually time-consuming.

The communicable disease regulations are similarly in process of revision. Again a representative advisory committee, this one composed entirely of physicians, proposes inclusion of two diseases among those to be reported, namely, Q-Fever and Vital (aseptic) Meningitis, and revision of 20 of the current communicable disease regulations.

Immunizations need to be stepped up, as pointed out in one of the reports to come before you.

A newly recognized hazard to health, that of ionizing radiation, is before the Legislature in the form of Bill 454, S. It would place over-all responsibility for radiation, as to State government, in the State Board of Health. There are those who advocate retaining under the Industrial Commission any jurisdiction as to radiation hazards in industry, and others who favor a separate commission to deal with this growing problem. The Legislature has the matter before it.

In addition to posing problems in public health, acknowledgements of essential assistance and of constructive leadership by the State Medical Society, its county societies, and physicians as individuals, are very much in order. We continue to depend on your Civil Defense Advisory Committee's brains, experience and support in moving forward in civil defense health services.

Your outstanding accomplishments by way of the Maternal Mortality Committee, and the cooperation you have given it as practicing physicians, have been instrumental in saving many lives of mothers in childbirth—and progress now under way toward reducing further deaths due to prematurity and in the neonatal period, are very real accomplishments, in which you and we can take deep satisfaction. The initial stimulation, provision of data pointing up needs, and so on, as provided by the Board through Doctor Hunter of our staff, are recognized by those of you who were most closely involved.

Time here tonight does not permit presenting other instances of close, effective cooperation resulting in accomplishments in the public interest that could not be expected were we to try to do them separately. Your patients (the people of the state) and the Board continue to be deeply indebted for this devotion to the advancement of that essential ingredient—health.

Speaker Leahy: We are honored to have with us this evening the President of the State Medical Society Auxiliary. Mrs. Gordon Schulz, Union Grove.

ADDRESS OF PRESIDENT OF WOMAN'S AUXILIARY

Mrs. Gordon Schulz: It is with pleasure, Doctors, that I stand before you to present the record of the accomplishments of your wives, the members of the Auxiliary to the State Medical Society of Wisconsin.

With emphasis from the American Medical Association and the National Auxiliary being placed on Community Service in the past year, we chose as our byline, "By Their Deeds You Shall Know Them". We requested that each member record her service hours. This was a national project.

Can you visualize the volunteer service hour total of 80,000 women in these United States? This is your Auxiliary working for you, and, we hope, establishing good public relations.

The popular vogue at the present time seems to be the hospital auxiliary. This is a fine project. The aims are specific and easily visualized. For this reason we find that many of our members are becoming more interested in the hospital auxiliary than in the medical auxiliary. This is only my personal opinion, but I feel that the greater percentage of hospital auxiliary work can be carried on by lay women. Only doctors' wives may belong to our Auxiliary, and we need them. I think you and your wives should discuss this. So far, it hasn't made a great deal of difference in our membership or projects, but I can see the writing on the wall.

MRS. GORDON SCHULZ
Union Grove

American Medical Education Foundation was our first priority project, and we are proud to tell you that the combined efforts of your wives brought this total to $4,100. May I remind you to use the Memorial and Appreciation cards? This money goes to the school of your choice, unbudgeted, undesignated, directly to the dean—a true gift.

I regret that we do not seem to be expert magazine circulators. Our *Today's Health* record does not show any improvement. Have you read the magazine

so that you can recommend it to your dentist friends for their waiting rooms, and to hospital administrators for hospital waiting rooms? We would appreciate your help and interest in this project.

In our other work we have followed the usual pattern of emphasis on home and highway safety, with special stress on child safety, particularly in reference to the discarded refrigerator and poisons.

Mrs. Arthur Kissling, Jr. and Mrs. Albert H. Pemberton, Milwaukee, serving coffee at the Woman's Auxiliary booth.

We have had an educational program in civil defense, with a fine demonstration at our midyear conference on "Grandma's Cupboard", the food and emergency supplies necessary for self-protection in event of atomic attack.

We have tried to be intelligent in medical legislation and have acted promptly on all directions from the State Society office. We thank you for your instruction and cooperation.

The method of accomplishing our Mental Health Christmas Gift Program was altered this year at the suggestion of the Wisconsin Association for Mental Health. The desire was to make this more personal, so each Auxiliary member received in the mail the name of a patient in a mental hospital who had not been remembered by family or friends for two years. On the card were listed articles that the patient could enjoy, specifications as to size, and so on. With great joy I tell you that from our membership of 1,700 women, 1,400 responded. Certainly this is the true spirit of Christmas.

When you visit the Auditorium, will you please stop at the Auxiliary booth and have a cup of coffee? While you are there, take a look at the display of our work. Also, you will see many pictures of some very attractive young ladies. This is our way of introducing to you the young women now in nurses' training on Auxiliary scholarships. You will notice there are many, some who became interested through our Medical Career Clubs, some who had the interest but not the funds and who heard of our program through schools and friends. We are proud to present these young ladies to you. Providing adequate nursing help is one of our ways of helping to ease your strenuous program.

We have a gift of $500 for your Charitable, Scientific and Educational Fund. We are happy to give you this. We are your Auxiliary. We wish you would request more of our services.

I have done the usual traveling around. Gordon has eaten TV Dinners many times, and observed the sink full of dishes, but it has been worth it. I have observed your wives in action, cementing relations between doctors' families, spreading good community feeling, working for you to keep medicine in its deserved respected position.

It has been a gratifying experience to be the President of the Auxiliary to the State Medical Society of Wisconsin. May I say that all I hoped for has not been accomplished; but if I have met with any success, it is due to the fine cooperation of the State Medical Society office, Girl Friday Leona, your wives, who are the workers in this organization, and the unselfishness of my dear husband and family.

Speaker Leahy: I am going to ask the President-elect of the Auxiliary, Mrs. G. A. Behnke, Kaukauna, to stand and be recognized.

Our next report will be by the Secretary of the State Board of Medical Examiners, Dr. T. W. Tormey, Jr.

REMARKS OF SECRETARY OF STATE BOARD OF MEDICAL EXAMINERS

Dr. T. W. Tormey, Jr. (Madison): This report is merely informative, to give you a rough idea of the general activities of our Board. I couldn't possibly answer the questions that I know many of you have, but I would invite letters of inquiry from any who are interested in anything particular as to the mechanism and the way we try to take care of Chapter 147.

Sixty-two years ago the Wisconsin Statutes provided for the first Board of Medical Examiners. Up to July 1, 1897, no license to practice medicine and surgery was required. After that date those who could present a diploma from an acceptable medical college, and who could give evidence of having been reputable practitioners in the state continuously since July 1, 1897, were granted a license without examination upon payment of a fee not to exceed $5.

Apparently, an individual beginning practice after July 1, 1897 could obtain his license by one of two means: First, he could submit to examination in the various branches of medicine and surgery and pay a fee of $10. Second, if he had a diploma from a medical college that required at least three courses of not less than six months each before graduation after January 1, 1897 and, after 1904, at least four courses of not less than six months each, the license could be obtained on presentation of the diploma and a $5 fee.

Beginning in 1903, a candidate for a license by reciprocity from another state was required to have passed a written examination; and, much later, the approved internship and basic science certificates were necessary.

Today, the educational, statutory, and Board requirements are a far cry from those of 62 years ago.

To keep abreast of the educational requirements of the physicians, and to try to provide the best possible medical attention to the citizens of this state, the present Board of Medical Examiners has continued to be interested in legislation they feel helpful.

This year, with the cooperation of the Public Policy Committee of this Society (for which we are most grateful), we are asking for statutory permission to allow graduate medical students to write the Board examination prior to completing the required approved internship, thus saving many of them long and inconvenient trips back to Wisconsin after internship, and saving them six or more nonproductive weeks, as under the present system.

In addition, we are asking extension of the temporary license statute to June 30, 1963. We have felt this privilege has made for improved physician and community relations, has enabled a qualified man to step in when the local physician is ill or away, and has kept those licensees from losing valuable weeks in becoming established.

The foreign graduate trainee program, sometimes known as the Temporary Educational Permit Program, is successful; and, at the suggestion of a number of individuals who work with these people and know of their desire for a full training program that may ultimately lead to specialty board qualifications, we have asked for a further two-year renewal of permits for those who qualify.

Other matters are in the discussion stage.

In addition to follow-up checking of old cases, the Board investigator has investigated problems relating to seventeen M.D.s, four D.O.s, six chiropractors, two chiropodists, two masseurs, and twenty-four quacks.

Along with those, there probably will be increased work in the narcotics line, since the Narcotics Bureau, presently in Milwaukee, is being moved.

The following figures are some indication of the Board's licensing activities in the past year:

1. Candidates examined for license in medicine and surgery by written examination, 190; by reciprocity examination, 180.
2. Forty-six foreign applicants out of over 300 inquiries were considered for acceptance under the amendment to Chapter 147.15, and of this number ten were licensed in 1958 and six have been licensed in 1959. Seven of the above are former holders of the Temporary Educational Permit Certificates.
3. Forty-six temporary educational permits were issued in 1958. Fourteen temporary educational permits have been issued to date in 1959.
4. Twenty-seven temporary licenses were issued in 1958.
5. There are 344 physical therapists and 184 chiropodists registered for 1959.
6. There are 5,042 physicians registered for 1959, and of this number 4,180 are listed as practicing in Wisconsin.

We are now in the process of preparing to mail the new Register.

Again, I extend the thanks of the Board of Medical Examiners to you for the privilege of presenting this brief report.

Speaker Leahy: Next we will hear from the President of the Charitable, Educational and Scientific Foundation, Dr. W. D. Stovall.

REMARKS OF PRESIDENT OF CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION

Dr. W. D. Stovall (Madison): This House always has serious matters to consider. They might be categorized in two phases: First, the effect of advancing organizations, social and civic, upon organized medicine, per se . . . how it affects the practice of medicine and the patient relationship.

Second, what impact does organized medicine have upon the philosophical thought which brings out the social organization that you have to consider so seriously in relation to your patients?

It is sort of like which comes first, the hen or the egg. It seems to me that you have to consider seriously what impact you have upon the thoughts of people, as to how they will organize society, because you are practicing in an organization of society, and that you cannot help. However, you can help how society is organized, and that is what we are talking about here tonight.

Your impact is how you act, how you behave, what you do to make a contribution to this social organization.

I am afraid of something. I wonder how many really listen. I wonder how many here really know the details of the Charitable, Educational and Scientific Foundation and why it was organized, and whether or not you are interested in it. Is it just another do-good organization? Of course it is do-good. That is all medicine is about, anyhow—doing good.

This Society must make an impact upon what medical practice stands for, and your volunteer contribution to that determines how much money we will have to determine that impact. I must say it is relatively small. Only 600 physicians in Wisconsin last year made a $10 contribution to the Charitable, Educational and Scientific Foundation of this Society.

Now let me show you how many people are in this organization and how well you are represented in it. There are 53 people elected by each county medical society. There are 25 officers and Councilors of the State Medical Society, and two nonmedical Trustees, 80 Trustees altogether. All but two of them are doctors.

The next important thing is this: What do we do, anyway? Well, we do a variety of things. Our most important thing as far as you are concerned is this: We are talking here tonight, and we talk at other times, about government running our Society. Who gives the largest number of scholarships to medical students who are needy, in order to help them get the education they need? The government. The government gives research scholarships. They give all sorts of scholarships. How many do we give to medical students who need help, to be sure that intelligent, conscientious, humanistic, earnest men are going into medicine? How much of a contribution do we make to that? It is damned little.

This Charitable, Educational and Scientific Foundation has about $55,000 out on loan to medical students who need money to get through their senior year or to progress from their junior year to their senior year.

Members of this House, I think if you will stop to think about it you will realize that giving to the Foundation is really a very important thing for you to do. I know that the government is making inroads on your taxes. I know it only too well this year. Nevertheless, this can be taken from those taxes; and when it is taken from the taxes it does not relieve you of all taxes, but it helps.

That may not be the reason, however, why you give to this Foundation. You want to make an impact. You want to have men practicing medicine who can represent the ideals and the standards that you have. We can determine that by selecting those to whom we give help in getting their medical education.

There is another thing we do. Some of our own members, as they come to the termination of life after having practiced and having loaned themselves to the welfare of the citizens of their own community, find themselves, by accident or otherwise, in need of help. Who is going to help them? The government? Sure, let the government do it. Public assistance. But we don't like the government doing these things. What do we do about it? We can do something about it.

We are not the only state medical society in this Union that is doing something about these problems. There are quite a few, and some of them are doing remarkable things. They are actually organizing public health organizations for whole communities, and doing a wonderful job serving the public health needs in those communities and conscientiously facing up to those needs. We need money for this.

We need money for our Museum. How are we going to portray to the public what the position of medicine is in the social order unless we do it through education? What is the best sort of education? Museums. We can have a Museum in this state that will be an honor not only to this Society but to each one of us as citizens of Wisconsin, portraying what the position of medicine is in the advancement of science.

Mr. Speaker, there has been some discussion as to what our voluntary contribution should be next year to the Charitable, Educational and Scientific Foundation. Up to now it has been $10. We are recommending that the Executive Committee of the Council maintain this voluntary contribution at $10, but we earnestly plead that every member of every county medical society make a contribution of $10 and that he make an additional contribution if possible, so that we can build this Fund up to at least $200,000 in order that we can help as many medical students as possible. There are 14 applicants for aid at the present time for whom this Fund has no money.

This is my report for the Foundation, Mr. Speaker, and I hope it does not fall upon deaf ears. I want you to be interested. I want you to listen. Furthermore, if this does not command your interest and does not persuade you that it is important, then oppose it. Do something about it. Don't just sit by and do nothing.

Before I close my report, gentlemen, I have a very personal word to say to this House. I want to express my appreciation for all that the House of Delegates of Wisconsin medicine have done for me for many, many years. You have honored me with every office in the Society, and I have done the very best I could. I stand for the principles you stand for, and I know the function of the doctor in organized society. I think nobody should take that function away from him.

At the present time I am one of your representatives to the House of Delegates of the American Medical Association. I have been there for a good many years—17 years, I believe, although I am not quite sure, but I think that is correct. I appreciate your confidence in sending me there to represent you.

I think I have come to the place now where it is time for me to turn these duties over to someone else. You have many able men who can fill this position.

At the last meeting of the House of Delegates of the American Medical Association I was elected a member of the Council on Constitution and Bylaws. I shall attend each meeting of the American Medical Association House of Delegates as long as I am a member of that Council; and as long as I can be influential and helpful with friends whom I know in that House, I shall be glad to serve.

However, I would like to say at this time that I would prefer not to be nominated as a delegate to the House of Delegates of the American Medical Association again. I think you should select someone else. My sincere thanks and deep appreciation for every honor that you have conferred upon me.

Throughout my life in Wisconsin I have no recollections of more pleasant associations, nor is there anything I value higher than my relation with the State Medical Society of Wisconsin and your friendly and cordial relations to me.

(The audience arose and applauded.)

MAKE YOUR "IMPACT" TOWARD ORGANIZED MEDICINE NOW THROUGH A CONTRIBUTION

TO THE

Charitable, Educational and Scientific Foundation

Your support of the State Medical Society's Foundation is the most worthy contribution you can make toward the advancement of medical progress and the preservation of the past . . . . right here in Wisconsin. Contributions are tax-exempt and are utilized as described below. Contributions can be ear-marked for a specific project of the Foundation or left to the discretion of the Foundation board.

STUDENT LOANS

Since this project was started, 68 medical students have received loans, and many applicants have been rejected for lack of funds. The committee feels that a total of $250,000 is needed for this activity. Currently, about $60,000 is available, greatly helped by a bequest of $10,000 by Mrs. Reginald H. Jackson in memory of her physician husband.

SCIENTIFIC MEDICINE

Grants have been received and, of course, are being used to promote such projects as those in studying certain phases of hearing loss; inhalation therapy; and other scientific programs.

MEDICINE AND ITS HISTORY

Substantial strides have been made to accomplish the complete restoration of the Military Hospital at Fort Crawford, Prairie du Chien, where Doctor Beaumont conducted many of his experiments upon Alexis St. Martin.

Items of medical interest are being constantly collected: Murphy buttons, old instruments, diaries, and other memorabilia, showing the tremendous contributions of the science of medicine in Wisconsin and nationally.

CHARITY BEGINS AT HOME

There are the occasional physicians who encounter physical and financial hardships. A limited, but very much needed, program is being developed to give them the "lift" they so desperately need.

TO SMS FOUNDATION:
Box 1109, Madison 1, Wis.

I am enclosing a contribution of $_____ for ☐ Student Loans ☐ Scientific Medicine ☐ Medical History ☐ Physician Assistance ☐ Your Discretion

NAME_____ STREET_____ CITY_____

REFERENCE OF REPORTS

Speaker Leahy: May I announce to the House that the President's Advisory Committee on the Constitution, Bylaws and Organization of the State Society and its component societies will meet at 2:00 p.m. tomorrow in Room 507 of this hotel. Any interested member of the Society is invited to appear before the Committee to present his views.

So that delegates may be advised as to which reference committees will hear the various reports and recommendations submitted, this announcement is now made on the subject. Where the subject matter is related, your Speaker has made every effort to refer those matters to the same reference committee.

Resolutions 1 through 5 will be referred to the Reference Committee on Resolutions.

The reports of the Committee on Public Policy, the Committee on Hospital Relations, the Council on Scientific Work, the Council on Medical Services, the Committee on Civil Defense, and the Committee on Medical Education and Hospitals will be referred to the Reference Committee on Standing Committees.

The reports of the Editorial Board, the Commission on State Departments and all of its divisions, the Secretary's report, and the reports of the President and Treasurer and AMA Delegates will be referred to the Reference Committee on Reports of Officers.

The reports of the Commission on Medical Care Plans, the Council and its supplementary report, with the exception of Resolutions Nos. 6, 7 and 8, the Charitable, Educational and Scientific Foundation, and the matter of dues for 1960 will be referred to the Reference Committee on Resolutions.

Resolutions Nos. 6, 7 and 8 are referred to the Reference Committee on Reports of Officers, which is considering the report of the Commission on State Departments.

It is a privilege as well as an opportunity for any interested member of the Society to appear before these committees and present his views on any matter properly before them. Delegates who are interested in any particular matter are especially urged to be present.

The House will now proceed with the selection of a Committee on Nominations.

(A brief recess was taken.)

COMMITTEE ON NOMINATIONS

Vice Speaker L. H. Lokvam (Kenosha): The House will please come to order.

Mr. Secretary, will you please call the roll of the districts, and will each district respond by announcing its nominee for the Committee on Nominations.

(The result of the caucus for members of the Committee on Nominations was reported as follows:)

First District _____J. F. Wilkinson, Oconomowoc
Second District _____R. W. Kreul, Racine
Third District _____Peter B. Golden, Madison
Fourth District _____W. P. Hamilton, Dodgeville
Fifth District _____J. F. Walsh, Port Washington
Sixth District _____Ernest A. Strakosch, Oshkosh
Seventh District _____B. C. Dockendorff, Arcadia
Eighth District _____Harold A. Aageson, Oconto
Ninth District _____M. V. Overman, Neillsville
Tenth District _____O. G. Moland, Augusta
Eleventh District _____C. J. Picard, Superior
Twelfth District _____S. W. Hollenbeck, Milwaukee
Thirteenth District _____W. P. Curran, Antigo

Vice Speaker Lokvam: The Chair will entertain a motion that these nominees constitute the Committee on Nominations.

Doctor Nordby: I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Golf winners: Dr. Durward Baker, first low gross (75); Dr. Paul Purtell, senior low gross traveling trophy (84); and Dr. C. L. Budny, second low gross (77); all Milwaukeeans.

Vice Speaker Lokvam: The Chair recognizes Doctor Strakosch for a report at this time.

REPORT OF PRESIDENT'S ADVISORY COMMITTEE TO STUDY CONSTITUTION AND BYLAWS AND ORGANIZATION OF STATE MEDICAL SOCIETY OF WISCONSIN

Dr. E. A. Strakosch (Oshkosh): About two months ago our President appointed an Advisory Committee to study the Constitution and Bylaws and organization of the State Medical Society. This Committee, of which I have the honor to be Chairman, consists of Drs. G. E. Collentine, Jr., of Milwaukee; S. W. Hollenbeck, of Milwaukee; George Nadeau, of Green Bay; Charles Stoops, of Madison; John P. McCann, of La Crosse, and H. A. Aageson, of Oconto.

As you can see, with the exception of its Chairman this Committee is quite heavy on cerebral power. The purpose of the Committee is clear. Its

task is difficult. It will consider the population and physician trend of the future in the state, and it will take the Constitution, Bylaws, organization and its activities apart, compare them with those of other societies, study carefully each part, and will attempt by elimination of a few, refurbishing of others, replacement of some, and finally reassembling of all again, to make recommendations to your President by 1960 to have the Society more streamlined, more integrated, to meet the challenge which Doctor Hildebrand so eloquently and brilliantly stated.

All members of the Society are invited. Let us partake of your views. This is your Society, so please come. We will meet at 2:00 p.m. tomorrow in room 507.

Vice Speaker Lokvam: All delegates have been reminded by the Secretary's office of that provision of the Bylaws providing that all new business first introduced at this time must be introduced through the Council, constitutional officers, committees of the Society or of the House, or officers of the House.

Is there any further business properly to come before the House at this time?

ADJOURNMENT

Vice Speaker Lokvam: The House is adjourned until 7:30 p.m. tomorrow evening.

(The meeting adjourned at 10:15 p.m.)

Dr. Edward Birge, assistant professor of pathology, MU School of Medicine, Milwaukee, was one of several pathologists who conducted daily demonstrations of surgical and autopsy tissue at the scientific exhibit of the SMS Section on Pathology and the Wisconsin Society of Pathologists.

SECOND SESSION

Tuesday, May 5, 1959

The second session of the House of Delegates convened at 7:40 p.m., Dr. J. D. Leahy, Speaker of the House of Delegates, presiding.

Speaker Leahy: Will the meeting come to order.

The first item is the report of the Credentials Committee. Doctor Lokvam, Chairman.

REPORT OF COMMITTEE ON CREDENTIALS

Doctor Lokvam: Mr. Speaker, for the second session of the House of Delegates the Committee on Credentials has verified the registration of 54 delegates and 13 alternate delegates entitled to vote at this session of the House of Delegates. In addition, 19 alternate delegates and 5 Councilors and 2 officers have registered their attendance.

Mr. Speaker, I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 67, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House, to stand for the entire session.

Doctor Nordby: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Speaker Leahy: At this time I would like to call on Doctor Fox, Chairman of the Council, for a supplementary report of the Council.

SUPPLEMENTARY REPORT OF COUNCIL

Doctor Fox: At this time I should like to report the deliberations of the Council at its regularly scheduled meeting at noon today. Of the matters under consideration, two were held over from previous meetings and a third was the result of a Council committee meeting during the current session of the House.

For some years the campaigns of the American Medical Education Foundation to raise funds in Wisconsin for support of the nation's medical schools have been almost a personal project of our Council colleague, Dr. Albion Heidner of West Bend. While many physicians in Wisconsin have contributed generously to the appeals of their alma mater, the program of securing additional unrestricted contributions has been placed almost entirely upon Doctor Heidner's shoulders—a burden which he has carried both effectively and devotedly.

In recognition of the growing needs of our medical schools, the Council recommends that a special solicitation of funds for the American Medical Education Foundation become a project of the State Medical Society's Charitable, Educational and Scientific Foundation, and that a special committee be appointed for this purpose.

Second, at noon today the Scientific Committee of the Council presented a report of its meeting this morning, concerning matters of medical education at the University of Wisconsin Medical School and the operation of the Wisconsin General Hospital. This report was of an informational character only. The Committee will continue its study of the problem in an effort to find adequate solutions to the current shortage of clinical teaching patients and the operating deficit of the hospital.

Finally, in keeping with the traditions of the profession of medicine and in recognition of the obligations assumed by the Councilors and officers of the State Medical Society in the conduct of their duties on behalf of medicine and of the public health, the Council requests the consideration of the House to the following resolution.

I beg your indulgence because I realize that this resolution is coming at a very late time. However, for quite some time it has been the thinking of many of the members of the State Society that we should in some way adopt a more formal installation ceremony for our new officers. This resolution would in effect create the semblance of more dignity on the part of the electees and the electors as well.

No less a person than the President of the State Medical Society has told me that the one most memorable occasion that he had as national President of the American Academy of General Practice was when he assumed the office and took the oath of office as President of the Academy. Therefore, the Council forwards for your consideration the following resolution:

> RESOLVED, that the Bylaws of the State Medical Society of Wisconsin be amended by the creation of a new Section in Chapter V to read:
>
> "7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council."

Dr. R. S. Gearhart (Madison): Mr. Speaker, I would like to move for suspension of the rules in order that this matter may be considered by this House of Delegates tonight.

Dr. R. A. Straughn (Madison): I second the motion.

[The motion was put to a vote and was carried unanimously.]

Dr. T. J. Nereim (Madison): Mr. Speaker, I move the adoption of the resolution.

Dr. C. J. Picard (Superior): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Speaker Leahy: Next is a report by Dr. John Z. Bowers, Dean of the University of Wisconsin Medical School.

REMARKS OF DEAN OF UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

Dr. John Z. Bowers (Madison): It is very nice to have an opportunity to speak to the members of the House of Delegates of the State Medical Society.

I would like to start by reaffirming the fact that the stature of the medical profession depends in no small part upon the ability of medical schools to produce good doctors. It is in a sense unfortunate that there are not more frequent opportunities to discuss these matters with you and other members of our State Medical Society.

Dr. Bowers

First, the faculty.

During the past year we have appointed Dr. Francis Forster as Chairman of the Department of Neurology to succeed Dr. Hans Reese. Doctor Reese has made an outstanding contribution to medicine in Wisconsin and the nation, and we are pleased that he will continue as a member of our faculty. Currently Doctor Reese is in Japan as a neurological consultant.

We have been anxious to strengthen our Student Health program in an effort to offer more effective, 24-hour medical coverage for students. With the appointment of Dr. John Flinn as Director of Student Health most of these problems have been resolved, and we are pleased with the program that Doctor Flinn has developed. He is using the Student Health program as an important teaching resource. We are also integrating Student Health into the existing Medical School departments.

On September 1, 1959, Dr. Alfred Evans will assume the position as Director of the State Laboratory of Hygiene and Chairman of a newly established Department of Preventive Medicine. It would be impossible for any of us to express the admiration that we hold for our beloved colleague, Dr. William Stovall. Can any of us recall a scientist who has contributed so much in so many diverse fields? I shall not eulogize Doctor Stovall, because he is simply changing jobs. In recognition of his past and present contributions, our Board of Regents has asked him to continue on the faculty beyond the customary age of retirement. The very fact that this has been done in the face of longstanding tradition for automatic retirement is an expression of the respect in which our University holds Doctor Stovall.

This past year has seen us take steps to make our postgraduate programs more attractive. As a result we have had much greater interest in the program and larger attendance.

Under the direction of Dr. Arthur Siebens we are moving ahead to develop a new program in rehabili-

tation. An excellent staff has been assembled, and remodeling of hospital space to house this new facility is progressing well.

The Medical Alumni Association is moving ahead rapidly with its program to raise funds for the William S. Middleton Medical Library. In addition to the vital role of service and research for the more than 1,000 students and faculty at the Medical Center, the Medical School Library operates an important extension program to make books and periodicals available, as requested by mail or pick-up, to physicians across the state. We hope that you will feel free to use our Library Service and that the physicians of this state will continue the fine contributions that we are receiving for the Library Fund. We now have, in cash and pledges primarily from physicians, over $225,000. We will be glad to correspond with any physician who desires to contribute to this program.

During recent months you have undoubtedly read about the changing program at our hospitals. Since this matter is of vital concern to the physicians and the people of the state, I should like to point out a few aspects of the problem to you.

The essential point to understand is that the education of medical students *today* requires patients in greater number and greater variety than was true ten or more years ago. Especially since World War II, the national trend, stimulated in part by the American Medical Association and the Association of American Medical Colleges, has been to sharply reduce the number of lectures in the clinical years and to emphasize working with patients. The optimal pattern is for teaching from the bed patient in the junior year, with an increasing emphasis on outpatient teaching in the senior year.

Since the time this movement began we have seen across the country a decrease in the volume of indigent patients, the historical backbone of clinical teaching. All medical schools are increasingly using semi-private and private patients for teaching; and, in passing, I can say that there has been no significant reaction against this by private patients.

The situation at the Wisconsin General Hospital

University of Wisconsin Medical School, Madison, was awarded first place winner of the scientific exhibits by large hospitals and/or teaching institutions. The exhibit on "The Ulcerogenic Tumor of the Pancreas" won second place for Drs. E. H. Ellison and Thomas Wall of Marquette University School of Medicine, Milwaukee. Third place spot went to Columbia Hospital, Milwaukee, for its combined exhibits on "Research Projects" by Drs. M. A. Krembs, J. E. Conley, J. M. Sullivan, R. R. Koenig, and Gorton Ritchie.

is complicated by several factors. In our setting, the most important problem is that relating to a strict referral policy requiring that all patients, private and Welfare, coming to the hospital be referred by a physician. This policy is applied to University faculty and the families of graduate students as well.

Other factors contribute to the problems of assuring an adequate supply of teaching material.

The State Auditor's office recently interrogated county judges in regard to the decreasing referral of Welfare patients to Wisconsin General Hospital. Their responses were as follows:

Fourteen county judges stated that in their opinion the reason for decline of public patients was that more people are covered by hospitalization insurance. Fourteen said that hospitalization is taken care of by county welfare departments for recipients of social security aids, that is, old age, blind, disabled and dependent children. Nine said that local hospital facilities have been expanded and improved, and nine stated they thought the reason for a decline in public patients was improvement of local physician and surgical services.

The increases in our hospital charges have not been out of line with rising costs in comparable hospitals, and current rates are well below University Hospital costs in several adjoining states. But when we incur a deficit, such as results when Civil Service salaries are increased, we must raise our rates.

In obstetrics and pediatrics we have developed excellent programs with the other hospitals in Madison. These affiliations have materially strengthened our teaching program for senior students.

The program of comprehensive medical care at the Medical Center for the dependents of undergraduate students was begun this February, and shows promise of contributing some of the "bread-and-butter" type of cases which are so urgently needed in our educational program. As of this date there are 285 families participating in this program. Of these families, 84 have received care at the Medical Center.

It is obvious that we continue in a period of reorientation at the University of Wisconsin Medical Center. All medical schools go through such change from time to time. Perhaps ours has been a bit more concentrated. We have many men on our faculty who have made distinguished contributions to medical education in Wisconsin through the years. I believe that the new members of our faculty will be able to carry on a similar tradition.

Through the coming months I hope that the University of Wisconsin Medical School and this State Medical Society can work together to resolve some of the problems that are in fact a mutual responsibility. All reports and surveys at the national level indicate that the Medical School in Madison stands among the first ten in the country, but neither you nor I would be content to leave things as they are. Medicine is changing. The country is changing, and we must change with it.

Speaker Leahy: Mr. Crownhart will introduce some guests.

INTRODUCTION OF GUESTS

Secretary Crownhart: Mr. Speaker, I am glad to have the opportunity to introduce the Administrator of the University Hospitals for a reason that is particularly dear to my heart.

It just happens that he is a lawyer. With some reassurance in my own mind that the medical profession still finds it at least feasible to use attorneys in some phases of their activities, I would like to present to you Lloyd Hughes, the new Administrator, with whom there has been established a very fine liaison between the State Medical Society and the Wisconsin General and University Hospitals.

Mr. Lloyd Hughes: All I can say is that it is a great surprise to me to be introduced to this House at this time. I would like to echo Mr. Crownhart's words. I believe we have established a fine working relationship with the various committees with whom we have had the privilege to work in the State Medical Society; and with the continuing working relationships with those various committees and with the Society as a whole, I am sure we can go forward and offer Wisconsin the type of hospital care and medical education that it so rightly deserves.

Speaker Leahy: Doctor Hildebrand would like to introduce some guests at this time.

President Hildebrand: Mr. Speaker and gentlemen, it is a pleasure to introduce two members of the Wisconsin Chapter of the Student AMA who are with us tonight. I regret very much that Mr. Jack McKenna, from the Marquette University School of Medicine and the Marquette Chapter, is not here. He was here last evening but had to leave early, before he could be introduced.

It is a pleasure to have with us tonight Miss Patricia Joo, a sophomore student at the University of Wisconsin Medical School, and Mr. Don Shelp, who is also a sophomore at the University of Wisconsin Medical School. Will you both please stand and come up front so we can see you?

Dr. William Luetke, Madison, looks at one of the 35 scientific exhibits displayed at SMS 1959 annual meeting in Milwaukee.

Speaker Leahy: At this time we will hear from Dr. Kenneth Lemmer, Chairman of the Council on Scientific Work.

SUPPLEMENTARY REPORT OF COUNCIL ON SCIENTIFIC WORK

Dr. Kenneth E. Lemmer (Madison): By tradition the Chairman of the Council on Scientific Work has the privilege of appearing before you to discuss the scientific aspects of the Society affairs.

What I have to say to you will be brief, but I hope it will lead to a revival of interest on both a statewide basis and on the county level, in pure scientific matters.

It is of deep concern to the Council on Scientific Work that with the increasing complexity of medical practice there is an apparent inability to find the time and effort to absorb all the new knowledge which confronts us in our daily practice. Those of us directly associated with patient care know what physical demands are made on our time, and the infrequent intervals when we can conscientiously leave our community and patients for periods of rest or professional "recharging of our batteries" through postgraduate teaching.

These all are problems which we, individually, must face; and yet every effort should be made to snatch what we can of the barrage of teaching that is made available to us.

Drs. Walton D. Thomas and Edwin H. Ellison, Milwaukee, at one of the Tuesday noon round:able luncheons.

Since 1941 our Society has presented regional teaching programs, popularly called Spring Clinics in the early days. These concentrated one-day or half-day programs have met a real need. Of late years their popularity has declined, but we still feel they have a place, and your Council on Scientific Work will continue to present them on a somewhat limited basis this coming academic year. One three-day circuit will serve the northern tier of counties, and a second series will serve the western and central portions of the state during the winter months.

One current major activity is a proposed Speakers Service which the State Medical Society, through its Foundation, is making available to all county medical societies in the state. In reviewing the experience of county medical societies we have been concerned that many of them are no longer holding scientific programs, but are rather limiting their county meetings to other problems.

It has been felt by the Council on Scientific Work that efforts should be made to revive an interest in scientific medicine on a county level. We recognize that some counties are small, and in some of these instances the physicians have been reluctant to ask a speaker to appear and talk to ten physicians, even though those ten represented 90 per cent of the county membership.

Distances from Milwaukee or Madison and a small county society treasury, which could be tapped to reimburse speakers for travel expenses, have been added factors in a trend of having fewer and fewer county society meetings devoted to scientific medicine, or at least so it appears to those of us on the Council on Scientific Work.

To help meet this situation we are instituting a Speakers Service for all county medical societies, with speakers reimbursed by the Foundation, and all we ask of the county society is that it provide the best possible audience.

To make this project possible, $7,500 has been transferred to the Foundation, and financial support has also been assured by the State Board of Health, the Wisconsin Division of the American Cancer Society, the Wisconsin Heart Association and the WATA.

We want this program to succeed. Frankly, we aren't nearly as interested in serving Dane County or Milwaukee County as we are in providing speakers for Calumet County, Vilas–Oneida, Door–Kewaunee, Ashland, and the many other smaller societies that may desire speakers but have been reluctant to invite them for reasons I have cited.

Before July 1 every county society will have available a directory of speakers and topics. It will facilitate matters if you and your county program chairman will file your request for speakers well in advance so that we can provide you with the type of program you desire.

Before closing, I want to comment briefly on the annual meeting program. I know you are busy here at the hotel with many important problems to the Society, but your presence in the Exhibit Hall and the meeting rooms will contribute to the success of our meeting. If possible, an interim meeting should be scheduled to allow the House of Delegates to take care of the necessary business. Then the annual meeting could be devoted to a scientific program with full attendance.

The annual meeting costs in the neighborhood of $20,000 each year, but only around $2,500 of this goes into the scientific program itself. That is for the speakers. The costs of scientific exhibits, hall rentals, union operators, entertainment at the annual dinner, and the costs of the House itself all add up to a sizable sum; so, you can see that the annual meeting is a major activity of the Society.

I am sure most of you read the *Wisconsin Medical Journal* with some degree of regularity. Those of us on the Council on Scientific Work are especially proud of the scientific portion of our official organ. Under the direction of Dr. Robert Baldwin,

this Journal ranks high among state medical journals throughout the country, and in terms of scientific editorship compares favorably with the Journal of the American Medical Association and specialty publications.

This report has been longer than I had intended it to be. However, it is my last and only chance to appear before you, as I now end my five-year term as a member of the Council, and by tradition no member can be reappointed after having fulfilled his five years of service.

It has been a privilege, and I hope that during the ensuing year the other Council members will have the pleasure of being besieged with requests for speakers and teaching programs. Nothing nicer could happen to a very dedicated group of physicians, I assure you.

Speaker Leahy: The next order of business will be reference committee reports.

The first committee to report is the Reference Committee on Reports of Officers, composed of Drs. R. S. Gearhart, Madison, Chairman; C. J. Picard, Superior; Gordon Schulz, Union Grove; J. G. Beck, Sturgeon Bay, and Gorton Ritchie, Milwaukee. Doctor Gearhart, will you report on behalf of your Reference Committee?

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Doctor Gearhart: The Reference Committee on Reports of Officers presents the following report:

The report of the President was considered in detail and your Reference Committee commends him for his untiring efforts in this time of stress. This very honest and frank report to the Society is summarized in Doctor Hildebrand's recommendation that the State Medical Society of Wisconsin create a permanent commission of five to undertake the continuing task of planning an immediate and long-range program to preserve the private practice of medicine in the State of Wisconsin.

This Reference Committee recommends that this report be accepted by this House of Delegates, and that such a program be immediately implemented in coordination with the present structure of the Council and the State Medical Society.

Mr. Speaker, I so move.

Dr. J. G. Beck (Sturgeon Bay): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: Your Reference Committee again offers its annual compliments to Dr. F. L. Weston, the Treasurer, for his usual brief but accurate and complete report of the financial standing of the Society.

Mr. Speaker, your Reference Committee recommends that the Treasurer's report be accepted, and I so move.

Doctor Nordby: Second.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: The report of the Secretary, Mr. C. H. Crownhart, was reviewed, and note was made of the fact that during the past year there have been three meetings of the House of Delegates, nine meetings of the Council and 74 meetings of the State committees, plus 32 county and district meetings attended.

A Tuesday noon roundtable luncheon discussion by Drs. Elwood Mason, John Amberg, and Paul Kimmelstiel, all of Milwaukee.

The activity of the Secretary's office, covering such items as the preparation of agenda for the above meetings, the March of Medicine, the *Wisconsin Medical Journal*, the activities of the Charitable, Educational and Scientific Foundation, hospital relations, Medicare, and the activities of the Woman's Auxiliary, to mention only a few, indicate the scope and load of work carried by this office.

Your Reference Committee recognizes and acknowledges the tremendous load of this office, and unanimously recommends the acceptance of this report.

Mr. Speaker, I so move.

Doctor Nordby: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: That portion of Dr. James C. Fox's report, as Chairman of the Council, introducing Resolutions Nos. 6, 7 and 8, from the Douglas County Medical Society, was referred to this Committee for action.

Resolution No. 6, concerning the use of county facilities for the treatment of tuberculosis:

Your Reference Committee recommends to the House of Delegates the passage of Resolution No. 6 with the deletion of the words "and the Wisconsin Legislative Council" from the last sentence, because of the feeling that the matter should not be taken to the Legislative Council until specific recommendations have been made by this Society.

It is with pleasure that this Committee reports that the Division on Chest Diseases has, as of sev-

eral months ago, instituted such a study and is now carrying on such a study.

Your Reference Committee recommends the passage of this Resolution No. 6, and I so move.

Doctor Picard: I second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: Resolution No. 7, relative to the authority of the State Board of Health regarding treatment programs in county facilities for the treatment of tuberculosis:

Your Reference Committee recommends the passage of this Resolution, with these changes:

"WHEREAS, the tuberculosis sanatoria of the State are under the supervision of the State Board of Health pursuant to Chapter 50 of the Statutes, and

"WHEREAS, some tuberculosis sanatoria have, because of the decrease in patient load, become dual purpose institutions and are operating under Chapter 46 and Chapter 49 of the Statutes and, as such, may not be subject to Chapter 50 of the Statutes; therefore, be it

"RESOLVED, that the State Medical Society prepare legislation which will clearly state all institutions which receive State aid for treatment of tuberculosis in whole or in part shall operate under Chapter 50 of the Statutes."

Chapter 50 of the Statutes, as I understand it, would give supervisory power to these institutions, either strictly tuberculosis hospitals or those that are operated as dual-purpose hospitals but that do have tuberculosis patients. They would have State Board of Health inspection and some supervisory power over that institution.

These changes are in line with the present request to the Attorney General of the State of Wisconsin that the legal relationship of the Wisconsin State Board of Health be re-defined. The opinions of the Attorney General will, of necessity, influence the final determination of these matters.

The Reference Committee therefore recommends the passage of this Resolution No. 7 as herein changed with the consent of representatives of the Douglas County Medical Society.

Mr. Speaker, I so move.

Doctor Beck: I second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: Resolution No. 8, relative to the treatment of tubercular patients with mental and emotional problems needing psychiatric care:

The Reference Committee feels that at the State level we have no authority to recommend to a county the closing of a county facility. However, the Committee appreciates the wisdom and necessity of having available to the psychiatric tubercular patient adequate psychiatric care, and therefore would recommend the transfer of psychiatric tubercular patients from Parkland Hospital in Douglas County to available state facilities where such adequate psychiatric care could be obtained. The further use of this Douglas County facility then becomes the rightful prerogative of that County.

The Reference Committee, again with the consent of representatives of the Douglas County Society, recommends the passage of this Resolution No. 8 with the above changes.

Mr. Speaker, I so move.

Doctor Nordby: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: Mr. Speaker, the report of the American Medical Association delegates has been circulated by mail to every member of the Society. This Reference Committee reviewed and approved the report. In addition, the Committee wishes to commend Dr. William Stovall for his many years of untiring service at this level.

Mr. Speaker, I move the adoption of this report.

Dr. P. B. Golden (Madison): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: The report of the Editorial Board of the *Wisconsin Medical Journal* has again been reviewed with pride in our Journal. Dr. R. S. Baldwin and his staff should be complimented in their efforts to constantly improve the Journal.

Mr. Speaker, the Reference Committee recommends the acceptance of this report, and I so move.

Dr. Gordon Schulz (Union Grove): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: In the report of the Commission on State Departments, submitted by Dr. T. W. Tormey, Jr., it is noted that the ten divisions of the Commission render a very unique service to the membership of the State Medical Society and to the public at large by effecting a real degree of coordination between practicing physicians, voluntary organizations throughout the state, and governmental agencies in the provision of certain medical and health services to the people of Wisconsin.

The Reference Committee recommends that a thorough study and analysis of this coordination between medicine and voluntary and governmental agencies would improve the understanding and simplification of the approach to many of these health programs.

In addition to the reports reproduced in the Delegates' Handbook, (printed in the July issue of the *Wisconsin Medical Journal*) the following division chairmen of the Commission on State Departments appeared before the Reference Committee with supplementary reports:

1. Dr. L. M. Simonson, Chairman of the Division on School Health, recommends through his Division that, although we should emphasize the necessity of the first three Salk injections, in the present state of our knowledge this Division suggests that a fourth injection be given if more than two years have elapsed since the third, and that this recommendation be inserted on page 9b–13 of the Delegates' Handbook at the end of the first paragraph relative to "Polio Vaccinations", in the Joint Report on Immunization Practices in Wisconsin. (Printed on page 441 of July issue).

The Division further recommends with urgency that local physicians take an active part to the end that the program of all immunization be completed prior to the time the preschool child enters school.

The joint report on "Immunization Practices in Wisconsin", dated April 10, 1959, as submitted by the Division on School Health and the Division on Maternal and Child Welfare, as circularized to all members of the State Society, is recommended for careful scrutiny and guidance by the membership-at-large.

2. The Division on Geriatrics, headed by Dr. A. M. Hutter, recommends that the House of Delegates authorize the State Medical Society to take an active part in the development of a statewide Conference on Aging prior to the White House Conference on Aging in 1961.

Your State Society will be represented at conferences in Washington, D. C. and Ann Arbor, Michigan relative to this subject during the current year.

The Division further recommends that the Division on Geriatrics be authorized to accept its full responsibility in the planning and conduct of regional conferences on a statewide level, to the end that medical and health aspects of the care of the aged receive due recognition and attention.

The Division on Geriatrics recommends that its name be changed to the Division on Aging (this to comply with nomenclature generally used nationally).

The Division recommends that county medical societies take a leading role in the development of local conferences designed to acquaint the aged and other persons interested in the problems of the aging.

3. Dr. H. A. Anderson, Chairman of the Division on Chest Diseases, reports that this Division has concentrated its efforts largely on the programs of the use of mobile units and the study of tuberculosis and the use of sanatoria facilities. This latter study is to be correlated with the action of the Council, as reported elsewhere in this report.

4. Dr. George Nadeau, Chairman of the Division on Visual and Hearing Defects, appeared before the Reference Committee to encourage the promotion of present standards of testing by motor vehicle authorities. The Division suggests that we should think in terms of the total driver rather than just in terms of eyes and ears.

5. Dr. E. D. Schwade reported in detail on the Division on Nervous and Mental Diseases, explaining the following recommendations:

(a) The Division recommends active support for the passage of bills proposed before the Wisconsin Legislature—Bill No. 1, S., to create a board for mental health programs, to coordinate all mental health organizations in the State in an advisory capacity; Bill 2, S., for the establishment of community all-purpose guidance clinics throughout the State; Bill 3, S., development of a center for the very emotionally disturbed child, to be established at Madison and in close proximity to the University of Wisconsin, as outlined in last year's report.

(b) The Division recommends that the Society oppose legislation for certification of clinical psychologists.

(c) The Division recommends that the Society work toward clarification of the present interpretation of "insanity before law".

(d) The Division recommends that it expedite its study on tranquilizers, with an early report in the *Wisconsin Medical Journal* to the doctors in Wisconsin.

(e) The Division recommends that the membership of the State Medical Society be urged to actively work with the lay groups for mental health, but that this liaison be real and active, and that these groups not be permitted to merely use the name of the doctor if his services are not actually used.

(f) The Division recommends that the study of the "second injury clause" be actively followed in an effort to eliminate the inequities in the present "second injury clause" as it applies to a man with an amputated arm or leg, including such groups as epileptics and diabetics.

Reference Committee members: Drs. R. S. Gearhart, Madison, Chairman, Gordon Schulz, Union Grove, and J. G. Beck, Sturgeon Bay.

The Reference Committee, after careful review of the report of each of the ten divisions of the Commission on State Departments, including the above supplementary reports, moves for the approval of the full report of the Commission on State Departments as submitted by Doctor Tormey.

Mr. Speaker, I so move.

Doctor Willson: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Gearhart: Dr. C. N. Neupert, reporting for the State Board of Health, is commended by this Committee for his help in reaffirming the role of the State Board of Health in its relationship to the practice of medicine.

Dr. T. W. Tormey, Jr., reporting for the State Board of Medical Examiners, clearly apprised the Society of the ever-present problems of licensure and protecting of the public from unqualified practitioners.

Dr. J. S. Hirschboeck, Dean of the Marquette University School of Medicine, and Dr. John Z. Bowers, Dean of the University of Wisconsin Medical School, are commended by this Reference Committee for their continuing efforts to correlate medical education with medical practice in Wisconsin.

Mrs. Gordon Schulz, Union Grove, retiring President of the Woman's Auxiliary to the State Medical Society, gave a most interesting and honest report of the work of her organization, with the plea that the State Society call more frequently upon the Auxiliary for the help which they so willingly and effectively give. This Committee not only wishes to thank Mrs. Schulz and the Auxiliary, but also strongly urges the county medical societies at a local level to utilize the extremely active and valuable help that our ladies are so anxious and so able to give us. This report is received with deep appreciation.

Mr. Speaker, I move the adoption of this report as a whole.

Dr. M. D. Davis (Milton): I second the motion.

[The motion was put to a vote and was carried unanimously.]

Lunch Time!

DR. H. M. COON

Milwaukee

Speaker Leahy: Thank you very much, Doctor Gearhart, for that fine report.

The next report is that of the Reference Committee on Standing Committees. Dr. R. M. Waldkirch, of De Pere, Chairman. Other members are Drs. H. W. Carey, Lancaster; H. M. Templeton, Barron; S. L. Chojnacki, Milwaukee, and E. W. Humke, Chilton

Doctor Waldkirch, will you report on behalf of your Reference Committee?

REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Dr. R. M. Waldkirch (De Pere): The Reference Committee on Reports of Standing Committees has reviewed in detail those reports assigned to it.

Our Committee was gratified at the good attendance by members of the House at our meeting, and much valuable comment was received from all who were present.

The report of the Council on Medical Service emphasizes problems of industrial health, rural health and public information. Your Reference Committee recommends approval of the report with the following comments:

1. The Reference Committee concurs with the recommendation of the Council on Medical Service that the Chairman of the Committee on Industrial Health be a member of the Council on Medical Service. We urge that this request be recognized.
2. The Council is to be commended for the completion of the Medical Press Guide which will be ready for distribution to the membership, newspapers and other media about mid-June. The Committee hopes that physicians will become familiar with it and will use it as a basis for the development of closer relationships with news media.
3. Industry is increasingly cognizant of its responsibilities for the health protection of the workman, and this trend is to be commended. We urge the Committee on Industrial Health to encourage industry to appoint physicians from their communities to guide them in medical matters, employment examinations, to suggest safeguards in the use of narcotics, and to assist them in their health and safety programs. With the cooperation of physicians this effort will be of assistance to industry and physicians, and protection to the public.
4. The Reference Committee is pleased that special emphasis is contemplated in the area of rural health. We urge continued attention to problems of locating physicians for rural communities and the development of closer liaison with rural programs in this state.

Your Reference Committee recommends special commendation of the Council on Medical Services and its Chairman, Dr. D. M. Willison, Eau Claire.

Mr. Speaker, I move acceptance of this portion of the report.

Dr. W. S. Freeman (Beloit): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Waldkirch: The report of the Council on Scientific Work is particularly encouraging to the Reference Committee, and it heartily endorses its plans to provide county medical societies with scientific programs financed through the State Medical Society Foundation.

This Reference Committee recommends the delegates from the county societies call to the attention of their county officers the desirability of a proper balancing of their county meetings between scientific and socio-economic matters, and that attention be given to the possibility of presenting these subjects at separate meetings. The new scientific Speakers Service will be of particular value to smaller county medical societies, and it is hoped that these societies will utilize the service to the utmost advantage of their members.

The Reference Committee wishes to commend the Council on Scientific Work for its excellent scientific program arranged for this meeting. We also wish to call to the attention of the House of Delegates the excellent work that Dr. K. E. Lemmer and his Committee have done in presenting scientific programs both on a state and county level.

Mr. Speaker, I move the adoption of this portion of the report.

Dr. E. W. Humke (Chilton): I second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Waldkirch: The perseverence and determination of the Committee on Civil Defense in its efforts to look after the health needs of the people of Wisconsin in the event of disaster, deserve the commendation of this House. At the same time this Reference Committee recognizes and commends Dr. C. N. Neupert, State Health Officers, and others of the State Board of Health staff for their continuing leadership in the health and medical aspects of civil defense.

It is recommended that the House of Delegates urge all members of the Society to cooperate fully in the implementation of programs for civil defense. County medical societies are urged to lend official cooperation and support to these efforts.

Mr. Speaker, I so move.

Doctor Strakosch: I second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Waldkirch: The report of the Committee on Public Policy was reviewed in detail, and it is our feeling that there is no need to comment on the specific bills since the Committee must determine its position in light of changing legislative situations.

However, the Reference Committee is impressed with the variety and broad scope of bills affecting public health and the medical profession. The Society owes a deep debt of gratitude to the seven members of the Committee on Public Policy who follow the day-to-day activities of the Legislature as guardians of the public health and protectors of the interests of the medical profession.

The Reference Committee wishes to emphasize that the Committee on Public Policy will of necessity assume responsibilities of substantial importance. Its responsibilities and obligations will undoubtedly increase in the future. The true effectiveness of the State Committee on Public Policy is measured by the interest and activity of similar committees at the county society level.

Their awareness of the critical importance of certain legislation to the public health and to the preservation of high standards of medical care is of no value whatsoever unless it reaches the members of the Legislature. Our failure to do so at the county and individual level, to quote the comment of the Committee on Public Policy, ". . . carries the probability of severe penalty. That penalty, of course, is punitive or thoughtless legislation resulting from ignorance of those facts."

Mr. Speaker, I move acceptance of this portion of the report.

Doctor Golden: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Waldkirch: The report of the Committee on Hospital Relations emphasized harmony between physicians and hospital administration, and better liaison between medical staff and the hospital board of trustees. Specific efforts should be made at the county level to implement this suggestion.

The Reference Committee has reviewed in detail the work of our staff representative for field service to medical staffs of hospitals. It is our opinion that the work that has been accomplished during the past year has been an excellent beginning, and carries with it an unusual challenge for the future.

The Reference Committee wishes to stress the fact that the activities of the Hospital Relations Consultant are thoroughly and continuously supervised by the Committee on Hospital Relations and the executive staff of the State Society.

The Council's recommendation for the amalgamation of several committees in the hospital relations field into a single Commission on Hospital Relations and Medical Education was not within the province of this Reference Committee; nevertheless, the Reference Committee expresses its full support of the proposal.

However, it sincerely hopes that the fine accomplishments of the Committee on Hospital Relations, as well as its projected plans as outlined in the recommendations of this Committee, will be carried on to the fullest extent, and that its work will be continued and expanded under direction of the new Commission.

Because adequate and up-to-date medical staff bylaws are the foundation of proper conduct of the medical staff and basic relationship to hospital administration, this Reference Committee urges each

delegate to examine into the adequacy of local medical staff bylaws and to bring them up-to-date wherever it is necessary.

Mr. Speaker, I move the acceptance of this portion of the report.

Dr. C. W. Stoops (Madison): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Waldkirch: The delegates are urged to review the many interesting facts revealed in a statistical study of the Society membership undertaken by the Committee on Medical Education and Hospitals. The Reference Committee feels that this report may be of substantial assistance to the proposed Commission on Hospital Relations and Medical Education in its future activities.

Those who appeared before the Reference Committee this morning repeatedly emphasized the critical nature of growing problems in medical education and the recruitment of properly qualified individuals to careers in medicine. We recommend that the Society undertake specific programs aimed at interesting eligible young people in careers in medicine and allied health fields.

Further, this Reference Committee recommends that each county medical society conduct one program a year to which young men and women may be invited for the purpose of informing them more fully of the opportunities in medical practice and the function of the physician in the community. This program can be conducted in several ways appropriate to that particular community.

Mr. Speaker, I move acceptance of this portion of the report.

Doctor Strakosch: I second that motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Waldkirch: I wish to personally thank the members of my Reference Committee for all the help they have given to me in rendering this report.

Mr. Speaker, I move acceptance of the report of the Reference Committee on Standing Committees as a whole.

Dr. J. F. Wilkinson (Oconomowoc): Second the motion.

[The motion was put to a vote and was carried unanimously.]

WERE YOU THERE?

RESOLUTION NO. 1

Introduced by: Trempealeau—Jackson—Buffalo County Medical Society

WHEREAS, the problem of compulsory Old Age and Survivors Insurance for physicians is an active topic of discussion in medical society groups; and

WHEREAS, the American Medical Association at its June 1958 meeting stated: "Any (such) poll should be taken on a state by state basis and the results transmitted to the delegates;" and

WHEREAS, at least six state societies have to date carried out such polls of their membership since the June 1958 meeting of the American Medical Association.

NOW, THEREFORE, BE IT RESOLVED, by the Tri-County Medical Society at its regular meeting on February 27, 1959, that its delegate to the House of Delegates sponsor a resolution authorizing an individual poll of all the members of the State Medical Society of Wisconsin to be conducted by a ballot through the mail on the question: "Are you in favor of Compulsory Federal Old Age and Survivors Insurance for the medical profession?"; and

BE IT FURTHER RESOLVED, that the results of this poll be published in the *Wisconsin Medical Journal.*

RESOLUTION NO. 2

Introduced by: Racine County Medical Society

WHEREAS, the American Medical Association and the State Medical Society of Wisconsin continue to oppose compulsory social security for self-employed physicians, and

WHEREAS, many delegates favored compulsory social security for physicians at the 1958 Annual Meeting of the State Medical Society of Wisconsin, and

WHEREAS, the Racine County Medical Society felt the need to re-evaluate this important issue on a local as well as on a state level, and

WHEREAS, a secret poll of Racine County members carried out in accordance with the above revealed that the majority were in favor of compulsory social security for physicians,

NOW, THEREFORE, BE IT RESOLVED, by the Racine County Medical Society, that it approves compulsory social security for self-employed physicians, and

BE IT FURTHER RESOLVED, that a secret poll be conducted by the State Medical Society to ascertain whether the majority of State Society members approve of social security for physicians, and

BE IT FURTHER RESOLVED, that if the majority approve compulsory social security for self-employed physicians, the State Medical Society of Wisconsin be advised to change its policy to that of favoring compulsory social security, and

BE IT FURTHER RESOLVED, that the state delegates to the American Medical Association be instructed to favor such a policy at the Annual Meeting of the American Medical Association House of Delegates in 1959.

RESOLUTION NO. 3

Introduced by: The Delegates of Brown, Door—Kewaunee, Fond du Lac, Outagamie, and Winnebago County Medical Societies which comprise the Sixth Councilor District

WHEREAS, the differences of opinion as to the operation and administration of Blue Shield medical-surgical care programs in Wisconsin have resulted in a jurisdictional and philosophical controversy, and have created confusion in the minds of the consuming medical public, and have further created a divided medical front among certain segments of the membership of the State Medical Society of Wisconsin; and

WHEREAS, all physicians agree that it is their sacred obligation to foster, preserve and protect the dignity of the fundamental private relationship that has always existed betwen patient and physician; and

WHEREAS, the medical profession in Wisconsin has pioneered in providing a medical-surgical care insurance program for the people of Wisconsin that both protects the interests of and engenders the relationships with the patient and the doctor; and

WHEREAS, continued controversy can only lead to the ultimate destruction of, and the loss of confidence in such voluntary prepaid medical-surgical care plans:

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates representing all physicians in the State of Wisconsin allow and approve of one parent Blue Shield medical-surgical care plan to be maintained, fostered, and operated by the State Medical Society of Wisconsin.

BE IT FURTHER RESOLVED, that the Council be directed to change the present personnel of the Commission on Medical Care Plans to be consistent with the numerical distribution of physicians in Milwaukee County as compared with the rest of the State of Wisconsin and that this Commission be solely responsible to the Council in all phases of operation, maintenance, and management of all society-sponsored medical care plans in the State of Wisconsin.

(continued on next page)

RESOLUTIONS (continued)

BE IT FURTHER RESOLVED, that this House of Delegates direct the Council to create, with the advice and aid of the newly-formed Commission, a new office of Insurance Manager.

BE IT FURTHER RESOLVED, that the activities of the newly created Insurance Manager should be controlled by and solely responsible to the Commission on Medical Care Plans.

BE IT FINALLY RESOLVED, the principles and contents of this resolution be effected by the Council before the next annual session of the House of Delegates.

RESOLUTION NO. 4

Introduced by: Manitowoc County Medical Society

WHEREAS, the State Medical Society of Wisconsin has been the subject of unfavorable publicity and unfortunate internal strife; now therefore, be it

RESOLVED, that Article II of the Constitution be read at the opening of any and all meetings of the State Medical Society of Wisconsin.

"The purposes of the Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life."

RESOLUTION NO. 5

Introduced by: Manitowoc County Medical Society

WHEREAS, Article IV, Section I of the constitution of the State Medical Society of Wisconsin limits active membership to members of the component county medical societies and the AMA; and

WHEREAS, the constitutions and bylaws of these component county medical societies require all active members to be duly licensed and registered physicians in the State of Wisconsin; and

WHEREAS, all officers of these component medical societies must be active members of their county and the State Medical Society; and

WHEREAS, the officers of the State Medical Society of Wisconsin are provided for by Article IX of the Constitution; and

WHEREAS, Chapter VI, Section 8 of the Bylaws of the State Medical Society of Wisconsin violates Article IV of the Constitution; and

WHEREAS, Chapter I, Section 3 limits the participation of only members in the proceedings of the annual session; now therefore, be it

RESOLVED, that Article IV of the Constitution, as to membership and officers, be strictly enforced and that Chapter VI, Section 8 of the Bylaws of the State Medical Society of Wisconsin be declared unconstitutional and of no effect.

REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO CONSTITUTION AND BYLAWS

Vice Speaker Lokvam: The last reference committee to report is the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws. Members of this Committee are: Drs. E. D. Sorenson, Elkhorn, Chairman; Donald M. Willson, Milwaukee; H. A. Aageson, Oconto; P. H. Gutzler, River Falls, and R. W. Mason, Marshfield.

Dr. E. D. Sorenson (Elkhorn): The Reference Committee on Resolutions and Amendments to the Constitution and Bylaws presents the following report.

Your Reference Committee looks with favor upon Resolutions Nos. 1 and 2, referable to polling the membership concerning compulsory social security. It suggests that such a poll include certain qualifying information, such as the age group of the physician and whether or not he is currently covered by social security by some manner of employment.

It is recommended that an explanatory statement regarding the impact of social security on the individual, predicated on current costs and income levels as well as possible expansion of rates and income ceilings, be included for each age group, in order that the balloting physician will be informed as to the particular problems inherent in social security for the self-employed.

It is further suggested that the limitations of benefits of continual employment after age 65 also be pointed out in this explanatory outline. The poll should contain a statement as to what would be the opinion of the voter if the current Keogh–Simpson bill (tax postponement retirement program for the self-employed) were to be passed.

Rather than make the results of such a poll mandatory upon the delegates to the American Medical Association, your Reference Committee recommends that, if there is adequate response to this poll, the results be considered as informative for the delegates to the American Medical Association and for the delegates of this House at its next session.

Mr. Speaker, I move the adoption of this portion of the report.

Dr. B. C. Dockendorff (Arcadia): I second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Sorenson: Resolution No. 3, introduced by the Sixth Councilor District, was withdrawn by that group, and thus its consideration by the Reference Committee was unnecssary.

In considering Resolution No. 4, the desirability of unity of all physicians in this State, in order that patients may continually receive the best of medical advances as they become available, should be apparent. The opening session of the House of Delegates could well start with this reminder, as indicated in Resolution No. 4 from the Manitowoc County Medical Society.

It is therefore suggested that the practice of reading Article II of the Constitution and Bylaws at the first session of this House of Delegates become a continuing one.

Mr. Speaker, I move the adoption of this portion of the report.

Dr. N. A. Bonner [Manitowoc]: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Sorenson: The Reference Committee has reviewed and discussed in detail Resolution No. 5, submitted by the Manitowoc County Medical Society. While it agrees in principle that physicians should be responsible for policy matters in the Society, it finds difficulty in correlating the duties of a physician secretary as outlined in Chapter V, Section 4 of the Constitution and Bylaws.

For this reason, it is recommended that this problem be submitted to the President's Advisory Committee on Study of the Constitution and Bylaws, with a specific request for introduction of an appropriate recommendation at the next annual session of the House of Delegates. This recommendation is not to be construed as an expression of lack of recognition of the motivation and efforts of the current Secretary of the Society.

Mr. Speaker, I move the adoption of this portion of the report.

Doctor Willson: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Sorenson: This Reference Committee has reviewed the report of the Council as printed, together with its supplementary report delivered by Doctor Fox last night. It wishes to acknowledge the efforts and activities of all concerned in their preparation.

The resolution transmitted requesting the formation of a distinct Ozaukee County Medical Society and a Washington County Medical Society, as approved by the Council, was favorably considered by the Reference Committee, and it therefore recommends approval of the request.

Mr. Speaker, I move the adoption of this section of the report.

Doctor Strakosch: Second.

[The motion was put to a vote and was carried unanimously.]

Doctor Sorenson: The Reference Committee is strongly in agreement with the opinion of the Council, as expressed by Doctor Fox, that it is inherent to quality medical care that individuals have their free choice of physician, uncamouflaged by anonymity of closed panel mechanisms. The Reference Committee agrees further that, as recommended, the Wisconsin delegation to the American Medical Association be advised to stand vigorously on this principle.

Mr. Speaker, I so move.

Doctor Golden: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Sorenson: The Council has proposed that the two Wisconsin senators to the United States Senate be petitioned with respect to HR 10, the Keogh–Simpson bill, as contained in its supplementary report.

Mr. Speaker, I move that this House approve the petition, and that signatures of the delegates present be secured at this time.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Doctor Sorenson: The petition will be circulated, and each member of the House of Delegates will have an opportunity to sign it this evening during this session.

The Reference Committee has reviewed the request for a change in the Bylaws providing for a Commission on Hospital Relations and Medical Education. In view of the immediate need for action to establish a Committee with this broad authority, it is believed that this change should be made promptly.

The change would require the deletion of Sections 6 and 8 of Chapter VII of the Constitution and Bylaws as now printed. The Reference Committee recommends that this be done.

Mr. Speaker, I so move.

Doctor Willson: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Sorenson: In lieu of Sections 6 and 8, a new Section should be established in Chapter VII (and the others renumbered accordingly) to provide for a Commission on Hospital Relations and Medical Education. As nearly as possible the terms of one-third of the members of the Commission shall expire each year, with each Commission member being appointed for a term of three years, except that initial appointments would be for one-, two- and three-year terms. The Commission shall consist of nine mem-

bers, to be appointed by the President, with confirmation by the House of Delegates.

The duties of this Commission shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

Mr. Speaker, I so move.

Dr. G. E. Collentine, Jr. (Milwaukee): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Who—Me?

DR. V. E. EKBLAD
Superior

Doctor Sorenson: This Reference Committee was impressed last night, as undoubtedly were all of the delegates, at Doctor Stovall's stirring presentation of the needs and accomplishments of the Charitable, Educational and Scientific Foundation. It wishes to urge the delegates to encourage all members whom they represent to increase the support of physicians by means of a minimum of $10 per year, which is the voluntary assessment recommended by Doctor Stovall, to aid in the highly desirable and necessary functions of this Foundation.

Mr. Speaker, I so move.

Doctor Gearhart: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Sorenson: The Resolutions Committee, in considering the report of the Commission on Medical Care Plans, wishes to point out to this House of Delegates the great amount of time-consuming effort of the many men on the Commission, its committees and the loyal members of the administrative staff. Special mention is made of the efforts of the Chairman, Dr. E. M. Dessloch, Prairie du Chien, which have been outstanding for a great many years.

In reviewing the report of the Commission for the past year, it views with some concern the rate of administrative costs, but acknowledges both the short- and long-range goals and aspirations of the Commission—for example, the recently announced Century Plan for coverage of the aged.

It recognizes that too little time has elapsed since the addition of the hospital rider protection to offer comments concerning this phase of operations.

The Reference Committee is confident that the Commission will continue to deal with the increasing complexities of third-party payment for medical services in the best interests of the public whom we serve.

Mr. Speaker, I move adoption of this portion of the report.

Doctor Nordby: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Doctor Sorenson: The Reference Committee has reviewed the finance report of the Treasurer, and notes that the expense of operations for the year approximated total income, with the exception of an increase in net worth of the *Wisconsin Medical Journal.*

In view of the unusual activities of the past year which are not apt to be repeated, and the net gain in operations noted in the previous annual report (for the year 1957), it is recommended that the dues remain the same as at present.

Mr. Speaker, I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Doctor Sorenson: And now, Mr. Speaker, I move adoption of this report as a whole.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: The Secretary has a report to make at this time.

SUPPLEMENTARY REPORT OF SECRETARY

Secretary Crownhart: Mr. Speaker and Members of the House:

I have several routine matters before making a supplementary report, which I felt was premature last night.

While we are circulating the petition, I doubt if I will speak long enough for Jean to get the petition around the room. In the event of her failure to do that, will you please come to the Speaker's table upon adjournment, and sign up.

It is a tradition of this House and of your annual meeting that Wednesday night be a somewhat social occasion as well as recognition of men who have contributed mightily to your profession. We are confronted on the management side with making guarantees to the hotel in trying to plan the room setup, and there seems to be a paucity of interest in attend-

ing the annual dinner this year. I hope that you will cooperate. If that tradition should be one which is becoming outworn, perhaps other arrangements will have to be made in the future.

I would bring my views to those of you representing county societies of the State and Board of Trustees of the Foundation which meets at noon tomorrow in the Pere Marquette Room.

Now, Mr. Speaker, I should like to address the House as its Secretary (not with a prepared statement) with reference to two matters. First, the events of the past months have been burdensome beyond description, and if it were not for a staff with depth and the ultimate in loyalty to their bosses, the efforts at accomplishments would not have been achieved to the degree that they exist today. Particularly does the Secretary extend his appreciation to Jean and Joan, Earl, Roy, and many other members of the staff who are here.

At the same time the Secretary would like to say to Doctor Quisling and to Doctor Hildebrand, both articulate, both persistent beyond description, both informed to the maximum degree, that were it not for their constant availability, advice and assistance, what we have been able to accomplish in the legislative halls would not have been as successful as it is today.

Two years ago, you will recall, we brought over here, with speed and dispatch, a roll call on chiropractic legislation, which had been in the Wisconsin Assembly that afternoon. In the past six weeks I have met with many of you, as have other members of the staff, and I am particularly pleased to tell you tonight that in my opinion the tide of uncertainty in the Wisconsin legislative halls on issues of vital public health has turned in favor of the views of medicine.

I say that tide is turning across the board, and it is with particular pride that I tell you it is bipartisan. The Democrats and the Republicans have dropped their Party labels in recognition that health knows no creed, no religion, no political faith, and the science of medicine and its strength and the soundness of its viewpoint are being increasingly recognized by the individual legislators.

As you leave this room take a look at the Neurolinometer in the back of the room—quite an impressive gadget, with four controls, two of which are wired to nothing. That particular instrument, secured from the Federal Food and Drug Administration, was taken onto the floor of the Wisconsin Assembly and there demonstrated by Assemblymen as what it means to prey on the credulous sick.

I am reminded of events and earlier activities in my professional life when I would know of a death and be retained to represent the survivors, and I would find that in those moments of sorrow books were delivered to the family as presumably having been ordered by the deceased—and not infrequently it was a Bible, by people who prey on credulity, on emotionalism, on fear, on suffering, not to the benefit of mankind but to the benefit of their own pocketbook.

The day is coming, ladies and gentlemen, when this Society is going to have to stand before the legislators of this State and demand the repeal of licensing acts for unqualified practitioners of the healing cults. They do not engage in their practice to remedy sickness. Their results are to increase the costs of medical care ultimately.

I say to this House of Delegates, and I say to the membership of the State Medical Society, that the chiropractic licensing act in this State should be repealed as soon as possible, granting that there must be some sort of grandfather clause until the final demise of that group in this State. You owe it not to yourselves but to the people. [Applause]

I would like to say another thing with respect to legislation. We have had in the person of Doctor Hildebrand and Doctor Quisling and the members of the Committee on Public Policy a group of individuals who have approached legislative problems in the sense of looking at a proposal not to blindly oppose it but to determine whether there is some element of justification in the proposal that lies before them and, if there is a reasonable element of justification, to admit it and to seek a harmonious legislative approach to that end.

Mr. C. H. Crownhart presents Dr. Fred J. Pfeifer, New London, with certificate and pin as he is welcomed into the "Fifty Year Club" of SMS. Doctor Pfeifer was one of 11 new members so honored.

I personally feel that their efforts are bearing fruit. Yet while they engage in those efforts, the staff of the State Medical Society must be prepared for their failure, if that should come about; and if the staff must be prepared, so must the doctors.

To that end we have endeavored to provide the physicians of this State, on a sufficiently widespread basis so that all of them may know of it, basic, honest information upon which you can rely and upon which you can convey your own impressions and the views of the medical profession to public officials.

STRIKING!

That effort is a heavy one, and sometimes it is almost spontaneous; but never have I addressed this House with greater faith in the strength of organized medicine than I do in the year 1959, when we cannot live in the complacency that the Legislature will just naturally go along with us.

Repeatedly legislators have told me, and have told our attorneys, Bob Murphy and Steve Gavin, about the communications that they have received from physicians concerning statesmanship. There is a certain Milwaukee physician—all I know about him is that he is in obstetrics and gynecology; I do not know his name—but I had read to me a letter that he wrote to some legislators. It was about a page and a half long. Whoever this unknown physician is, I would nominate him very sincerely for some type of public acclaim. He said words to this effect:

"Being in the field in which I am engaged, I do not expect that my patients will encounter the problems offered by the quacks who are in Wisconsin, nor will the babies born of them. But I not only attended high school and took my medical training and spent my years in internship and residency training, but I was inculcated from the days of my earliest medical education with the ideal that as a physician I give of my professional knowledge to the future welfare, safety and security of my patients.

"Mr. Legislator," he said, "with that commitment and with that obligation, I can only say to you that you should stand shoulder to shoulder with the medical profession of this State."

Gentlemen, if I can obtain that letter it will be circulated to every physician in this State, for indeed it reflects credit on the whole of medicine.

Now, one parting comment. The Secretary of the State Medical Society is beholden to no man in this position. He represents no county medical society, no specialty group, no geographic area. And while he is elected by the Council, that body gives him freedom of speech at all times.

The Secretary cannot represent an individual physician, be controlled by him or be bossed by him. No matter what the concentration of physicians is in an area, they are still individual members of the Society; and whether they are seventeen or ten or five or three hundred or a thousand, the mere mass weight of any geographical area cannot influence honest administration of the affairs of the State Medical Society. I represent the individual physicians of this State, and one is just as important as another.

The discharge of this particular responsibility of my office is guided by the motivations of sincerity and honesty, in full recognition that standing in front of the ranks of medicine puts the Secretary and his staff first in the sights of those who hold the guns of criticism.

Who better for the chiropractors to criticize than Crownhart? Who better for the naturopaths, who seek licensure in this State, to criticize than Crown-

hart? They don't want to criticize a doctor by name, but they want to criticize somebody by name, and why not Crownhart?

I am not afraid of it, and neither is your staff. We stand that criticism by the cults, by those opposing economic interests, no matter how sincere they may be, and by those who do not hold and who have not been educated in and who will never acquire the standards of a profession.

I was raised in the town of Superior, which in its early days was contemplated as being the metropolitan area of Wisconsin. I don't know if you know it (although probably Doctor Picard does), but at one time it was the largest city in the state geographically.

It is an interesting community, with its ore docks, its settlements, with all its physicians in Superior and none in the County as a whole. I was raised where the profile of civic life was outstanding. When the principal of the Superior State College appeared anywhere he was considered to be a man above men, honored for his ability, recognized for his distinction, and trusted as an adviser to the community.

Our family physician was Dr. J. C. Adams, who startled more than one medical meeting with some adroit trickery of the character of Doctor Arveson. He road in a horse and buggy, and wherever Doctor Adams went he was considered to be the physician of the community, and an outstanding one.

So were many others in civic life. But their profile was that of individual heights—men who stood above their fellow men because of their accomplishments, because of their dignity, because of their honesty. And that silhouette of their civic life hit those peaks.

Now, a century later, many others have achieved a pseudoprofessional status. The silhouette of the physician has merged with the silhouette of others, and there has been a gradual leveling process in the stature of individual men. Only through collective action today, sincerely thought out, honestly thought out, not the mimicry of information fed to you or to others for a given purpose or for propaganda, but weighed for its value, for its truthfulness—and only by collective action can medicine retain the stature that it once held as individuals.

Another six weeks and the legislative session will probably be at an end. I am hopeful that the burial ceremony will be an inclusive one. I feel a reasonable degree of assurance that it will be, but only to the everlasting credit of 53 county medical societies in this State, their officers, their delegates, and countless individual physicians who have contributed so much.

We in Madison at our best are but representatives of your collective strength. We have no vote to cast, no promises of support to give, only the plea that the legislator and the public official consider medicine as truly a profession, and one of which it must be proud, as you must be proud.

I am appreciative to you, deeply appreciative, and thank you for the opportunity of talking to you tonight.

ADJOURNMENT

Speaker Leahy: If there is no further business before this session of the House, we stand adjourned until 9:00 a.m. tomorrow morning.

[The meeting adjourned at 9:25 p.m.]

THIRD SESSION
Wednesday, May 6, 1959

The third session of the House of Delegates convened at 9:20 a.m., Dr. J. D. Leahy, Speaker of the House of Delegates, presiding.

Speaker Leahy: The meeting will come to order. The first order of business is the report of the Credentials Committee. Doctor Lokvam.

REPORT OF COMMITTEE ON CREDENTIALS

Doctor Lokvam: Mr. Speaker, at this third session of the House of Delegates the Committee on Credentials has verified the registration of 42 delegates and 12 alternate delegates entitled to vote at this session of the House of Delegates. In addition, 4 alternate delegates and 4 Councilors and 1 officer have registered their attendance.

Mr. Speaker, I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 54, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House, to stand for the entire session.

Doctor Nordby. Second the motion.

[The motion was put to a vote and was carried unanimously.]

INTRODUCTION OF GUESTS

Speaker Leahy: At this time we would like to present some guests to the House. Will Dr. G. B. Saltonstall, President of the Michigan State Medical Society, come up and say a word?

Dr. G. B. Saltonstall: It is a real pleasure to have the opportunity to bring you the greetings of the Michigan State Medical Society.

We had intended to arrive earlier last night, but the plane didn't fly. We finally arrived, and are being very nicely entertained. I would like to thank all of you for both Mrs. Saltonstall and myself for inviting us to your fine meeting.

Thank you. [Applause]

Speaker Leahy: We are happy to have with us also Dr. John Billingsley, of Newton, Iowa, President of the Iowa State Medical Society. Will he come up and say a word?

Dr. John W. Billingsley: Mr. Speaker and members of the House, I want to thank your Society for this opportunity to present the greetings of the Iowa State Medical Society to Wisconsin.

After the hassle from 7:30 in the morning to 3:30 in the afternoon at the final session of our own House of Delegates two weeks ago, which Doctor Gundersen attended, it is very fine to have such a calm meeting as this one this morning.

Thank you. [Applause]

Speaker Leahy: Also, we have Doctor Gundersen, who is on our program this evening. We will ask him to stand and take a bow. Doctor Gundersen. [Applause]

At this time our President, Doctor Hildebrand, will read his committee appointments.

PRESIDENT'S COMMITTEE APPOINTMENTS

President Hildebrand: As you know, it is customary for the President to make his committee appointments at the opening session in connection with his Presidential Address. However, because of a proposed committee change this was not done, and

WILLIAM B. HILDEBRAND, M.D.
Menasha

therefore in line with your recommendation yesterday concerning committee reorganization, I will consolidate the three committees which are now out of existence, and will read appointments to the new Commission on Medical Education and Hospital Relations, consisting of nine members, to include a Chairman.

Mr. Speaker, I wish to submit the names of the following appointees to standing committees of this House.

Committee on Cancer: There are six terms expiring. May I reappoint Dr. Ralph C. Frank, of Eau Claire, and Dr. Gerard I. Uhrich, of La Crosse, and appoint Dr. Roy C. Glise of Richland Center; Dr. Glenn A. Smiley of Delavan; Dr. Joseph J. Gramling, Jr., of Milwaukee; Dr. John F. Brown, of Rhinelander, and appoint Dr. Paul M. Cunningham, of Appleton, to serve as its Chairman.

Committee on Grievances: Three terms expire on this Committee. May I reappoint Dr. E. D. Sorenson of Elkhorn, and Dr. Elwood W. Mason of Milwaukee, and appoint Dr. Robert W. Mason of Marshfield. I should like Dr. Eugene J. Nordby of Madison to serve as Chairman of this Committee.

Council on Medical Services has three terms expiring. May I reappoint Dr. Charles J. Picard of Superior, and appoint Dr. Howard M. Templeton of Barron and Dr. William E. Acheson of Valders. I should like to reappoint Dr. Donald M. Willison of Eau Claire as Chairman.

Committee on Public Policy: There is one term expiring. May I appoint Dr. Norbert Enzer of Milwauke, and reappoint Dr. A. A. Quisling of Madison to serve as Chairman.

The *Council on Scientific Work* has one term expiring. May I appoint Dr. A. R. Curreri of Madison to serve. It is a tradition that the Council selects its own Chairman.

In place of the Committee on Hospital Relations, the Committee on Medical Education and Hospitals and the Committee on Coordination of Medical Services, we have a new *Commission on Hospital Relations and Medical Education.* This Commission consists of nine members. I have appointed members to staggering terms, three to serve for one year, three to serve for two years, and the remaining three to serve for three years.

For terms to expire in 1960: Dr. S. R. Beatty of Neenah; Dr. J. W. Boren of Marinette, and Dr. N. A. Bonner of Manitowoc.

For terms to expire in 1961: Dr. C. J. Picard of Superior; Dr. T. L. Squier of Milwaukee, and Dr. J. P. McCann of La Crosse.

For terms to expire in 1962: Dr. T. H. McDonell of Waukesha; Dr. R. S. Gearhart of Madison, and Dr. O. V. Overman of Neillsville.

Dr. John Z. Bowers and Dr. John Hirschboeck, the deans of the Marquette University School of Medicine and the Wisconsin University Medical School, will serve on this Commission as ex officio members. I shall appoint Dr. R. S. Gearhart of Madison as the Chairman of this new Commission.

Speaker Leahy: The next matter of business is the report of the Committee on Nominations. Doctor Lokvam will take the Chair, please.

Vice Speaker Lokvam: Before proceeding with the nominations, we will require confirmation of these appointments. I will entertain such a motion.

Dr. Jerome Fons (Milwaukee): I so move.

Dr. A. J. Sanfelippo (Milwaukee): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Vice Speaker Lokvam: We will proceed to the report of the Committee on Nominations.

Under the Bylaws the first order of business at the third session of the House is the report of the Committee on Nominations. Your Chairman reminds you that nominations by the Committee do not preclude additional nominations being made from the floor. We will act upon each nomination separately so as to permit additional nominations from the floor, if there be any.

I now call upon the Chairman of that Committee, Doctor Picard, to make his report, which under the Bylaws must be in the form of a ticket containing the name of the nominee or nominees for each of the offices to be filled at this session.

Will the Chairman of the Nominating Committee please report.

REPORT OF COMMITTEE ON NOMINATIONS

Dr. C. J. Picard (Superior): Mr. Vice Speaker and Members of the House:

The 1959 report of the Nominating Committee, composed of one delegate from each Councilor District, has the honor and pleasure to present the following nominees for the official positions in the State Medical Society:

For the office of President-elect: E. D. Sorenson, of Elkhorn.

For the office of Speaker of the House: L. H. Lokvam, of Kenosha.

For the office of Vice Speaker of the House: Dr. N. A. McGreane, of Darlington.

For the office of delegate to the American Medical Association to succeed Doctor Stovall, we nominate Dr. A. A. Quisling of Madison.

For the office of delegate to the American Medical Association to succeed Doctor Griffith, we nominate Dr. R. E. Galasinski of Milwaukee.

For the office of alternate delegate to the American Medical Association to succeed Doctor Quisling, we nominate Dr. W. B. Hildebrand of Menasha.

For the office of alternate delegate to the American Medical Association to succeed Doctor Galasinski, we nominate Dr. George Collentine, Jr., of Milwaukee.

Vice Speaker Lokvam: These nominations will be acted upon in order as presented by the Nominating Committee.

ELECTION OF OFFICERS

The first nomination by the Committee is that of Dr. E. D. Sorenson for the office of President-elect. Other nominations are in order at this time. What is your pleasure?

Doctor Strakosch: Mr. Chairman, may I move that nominations be closed and that Doctor Sorenson be elected by acclamation as President-elect.

Doctor Fons: Second the motion.

[The motion was put to a vote and was carried unanimously.]

Vice Speaker Lokvam: At this time it is customary to appoint a committee of three to escort the new President-elect to the House. I would like to ask Doctor Nordby, Doctor Strakosch and Doctor Kreul to escort the newly elected President-elect to the House before the conclusion of this session.

[The Speaker resumed the Chair.]

Speaker Leahy: The next nomination is that of Doctor Lokvam as Speaker of the House. Are there other nominations from the floor?

Doctor Willson: Mr. Speaker, I move that nominations be closed and that the unanimous ballot be cast for Doctor Lokvam.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: The next office is that of a Vice Speaker of the House. Dr. N. A. McGreane of Darlington has been nominated. Are there other nominations?

Dr. R. W. Kreul (Racine): Mr. Speaker, I move that nominations be closed and that the Secretary be instructed to cast the unanimous ballot for Doctor McGreane.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: The next nominations are for delegates to the American Medical Association. Dr. A. A. Quisling of Madison has been nominated to succeed Doctor Stovall. Are there other nominations?

Doctor Golden: Mr. Speaker, I move that nominations be closed and that the Secretary cast the unanimous ballot for Doctor Quisling.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: Dr. R. E. Galasinski has been nominated to succeed Doctor Griffith as delegate to the American Medical Association. Are there other nominations?

Dr. P. B. Mason (Sheboygan): Mr. Speaker, I move that nominations be closed and that the unanimous ballot be cast for Doctor Galasinski.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: Dr. W. B. Hildebrand has been nominated to succeed Doctor Quisling as alternate delegate to the American Medical Association. Are there other nominations?

Doctor Strakosch: Mr. Speaker, I move that nominations cease and that the Secretary be instructed to cast the unanimous ballot for Doctor Hildebrand to serve as alternate delegate to the American Medical Association.

Dr. R. A. Straughn: (Madison): Second the motion.

[The motion was put to a vote and was carried unanimously.]

Speaker Leahy: Dr. George Collentine, Jr., has been nominated to succeed Doctor Galasinski as alternate delegate to the American Medical Association. Are there other nominations?

Doctor Sanfelippo: I would like to move that nominations be closed and that a unanimous ballot be cast for Doctor Collentine.

Doctor Gearhart: Second the motion.

[The motion was put to a vote and was carried unanimously.]

INTRODUCTION OF GUEST

President Hildebrand: Mr. Speaker and members of the House, I am informed that Dr. B. B. Souster, President of the Minnesota State Medical Society, is in the House. Will he kindly come forward so that he may be introduced to the House of Delegates?

Dr. B. B. Souster: It is a pleasure and privilege to be here. It is nice to be here in this quiet atmosphere and sunshine. I talked to St. Paul a few minutes ago. It's 45 degrees above zero there, and raining. We love it because we haven't had any rain there since last August.

For the North Dakota folks, let me say it is snowing there. I think I'll go down to Florida after the ball game this afternoon. [Applause]

Speaker Leahy: The next order of business is the selection of a place for the 1960 annual meeting. The Nominating Committee has suggested Milwaukee. What is your pleasure?

Before we take up that matter, we will ask the committee to escort Doctor Sorenson to the platform.

[The audience arose and applauded.]

Drs. E. J. Nordby, Madison, E. D. Sorenson, Elkhorn, and E. A. Strakosch, Oshkosh.

REMARKS OF NEW PRESIDENT-ELECT

Doctor Sorenson: Members of the House and Officers of the Society:

I would like to assure the members of this House that I am very honored. I am very pleased that this House has shown confidence enough in my abilities and whatnot to elect me to this high office. I assure you that I will attempt to merit your confidence.

It is going to be a pretty tough grind to follow Doctor Hildebrand. He goes at a pretty fast pace. He is active, and he knows where he is going. I am going to watch him very closely this year, because I want to know where I have to go next year. [Applause]

SELECTION OF ANNUAL MEETING SITE

Speaker Leahy: Have you had a chance to think over your selection of a meeting place for next year? What is your pleasure for the 1960 meeting?

Doctor Willson: Mr. Speaker, I move that the 1960 meeting be held in Milwaukee.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

ELECTION OF COUNCILORS

Speaker Leahy: We will now proceed to the election of Councilors.

In the Seventh District to succeed Dr. J. C. Fox of La Crosse. Will the Seventh District please report its nominee to succeed Doctor Fox.

Doctor Dockendorff: The Seventh Councilor District takes pleasure in nominating Dr. J. C. Fox to succeed himself.

I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: In the Eighth District, to succeed Dr. J. M. Bell of Marinette.

Dr. C. E. Koepp (Marinette): Mr. Speaker, the Eighth District wishes to nominate Dr. J. M. Bell to succeed himself.

I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: In the Ninth District, to succeed Dr. R. E. Garrison of Wisconsin Rapids.

Dr. M. V. Overman (Neillsville): Mr. Speaker, the Ninth Councilor District wishes to nominate Dr. Robert Mason of Marshfield to succeed Dr. R. E. Garrison.

I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: In the Tenth District, to succeed Dr. R. G. Arveson of Frederic.

Dr. L. O. Simenstad (Osceola): Mr. Speaker, the Tenth District nominates Dr. Ralph Frank of Eau Claire to succeed Dr. R. G. Arveson.

I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: In the Twelfth District, to succeed Dr. James E. Conley of Milwaukee.

Dr. Edgar End (Wauwatosa): Mr. Speaker, the Twelfth District nominates Dr. William J. Egan of Milwaukee to succeed Dr. James E. Conley.

I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

Speaker Leahy: In the Twelfth District, to succeed Dr. E. L. Bernhart of Milwaukee.

Doctor Willson: Mr. Speaker, may I have the privilege of using the microphone? Thank you.

At the special meeting of the House of Delegates at Stevens Point last September, there were varied reactions to the dramatic resignation of Dr. Jerome Fons from the office of President of this Society. Perhaps enough time has elapsed since then to allow the delegates to realize that this action of Doctor Fons was not a manifestation of personal pique, nor was it an expression of greater loyalty to his County Medical Society, which was being censured at that time.

On the contrary, his resignation was a protest against a situation most dangerous to his State Society, and an expression of his impotence in the office of President insofar as a correction of this situation was concerned.

Doctor Fons has a long record of positive accomplishments in many capacities in the State Medical Society of Wisconsin. Doctor Fons continues to hold the interests of the people and of their physicians throughout the State of Wisconsin close to his heart.

Rather than repudiating the problems that existed within Wisconsin medicine, Doctor Fons has continued his efforts toward their solution. Last week he accepted an appointment as delegate to this House to fill the vacancy that occurred, and he is here in that capacity this morning.

Gentlemen, I can think of no more experienced and dedicated physician, whose wisdom and whose vote will contribute more to the decisions of the Council of the State Medical Society of Wisconsin, than Doctor Fons.

EXHIBIT HALL, MILWAUKEE AUDITORIUM, WITH 135 TECHNICAL AND SCIENTIFIC EXHIBITS

Mr. Speaker, with the unanimous approval of the delegates and alternate delegates of the Twelfth District, it is a privilege and honor to nominate Dr. Jerome Fons as Councilor for a three-year term, to fill the vacancy created by the expiration of the term of Dr. E. L. Bernhart.

I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

[The Vice Speaker resumed the Chair.]

Vice Speaker Lokvam: The next election is that of Councilor in the Thirteenth District to succeed Dr. J. D. Leahy of Park Falls.

Dr. Marvin Wright (Rhinelander): Mr. Chairman, the Thirteenth District nominates Dr. W. P. Curran.

Vice Speaker Lokvam: All in favor of this nomination, please say "aye"; contrary, "no". It is so ordered.

Are there further reports from reference committees? If not, does anyone wish an opportunity for the floor?

Vice Speaker Lokvam: Before entertaining a motion to adjourn, I think this House owes a debt of appreciation and gratitude to our retiring Speaker, Doctor Leahy. I would like the House to rise and express itself.

[The audience arose and applauded.]

ADJOURNMENT *SINE DIE*

Vice Speaker Lokvam: A motion for adjournment is in order.

Doctor Strakosch: I so move.

[The motion was severally seconded, was put to a vote, and was carried unanimously.]

[The meeting adjourned *sine die* at 9:55 a.m.]

ATTENDANCE AT HOUSE OF DELEGATES
MAY 4, 5, AND 6, 1959

	Sessions 1	2	3
SOCIETY:			
Ashland-Bayfield-Iron—			
J. W. Prentice, Ashland	o	o	o
J. M. Jauquet, Ashland	o	x	x
Barron-Washburn-Sawyer-Burnett—			
H. M. Templeton, Barron	x	x	x
W. B. Rydell, Rice Lake	o	o	o
Brown—			
L. C. Miller, Green Bay	x	x	x
J. L. Ford, Green Bay	o	o	o
R. M. Waldkirch, De Pere	x	x	o
S. L. Griggs, Green Bay	o	o	x
Calumet—			
E. W. Humke, Chilton	x	x	x
A. C. Engel, New Holstein	o	o	x
Chippewa—			
J. J. Sazama, Chippewa Falls	x	x	x
C. A. Kemper, Chippewa Falls	o	o	o
Clark—			
M. V. Overman, Neillsville	x	x	x
J. W. Johnson, Withee	o	x	o
Columbia-Marquette-Adams—			
R. T. Cooney, Portage	x	x	x
R. R. Rueckert, Portage	x	x	x
Crawford—			
V. C. Epley, Prairie du Chien	o	o	o
T. F. Farrell, Prairie du Chien	x	x	o
Dane—			
R. S. Gearhart, Madison	x	x	x
C. A. Doehlert, Madison	x	x	x
T. J. Nereim, Madison	x	x	x
N. M. Clausen, Madison	x	x	x
C. W. Stoops, Madison	o	x	x
R. P. Sinaiko, Madison	x	o	o
E. J. Nordby, Madison	x	x	x
H. M. Suckle, Madison	o	o	o
J. R. Steeper, Madison	x	x	o
R. A. Straughn, Madison	o	x	x
P. B. Golden, Madison	x	x	x
A. P. Schoenenberger, Madison	x	x	x
W. T. Russell, Sun Prairie	x	o	x
V. W. Nordholm, Stoughton	o	o	o
Dodge—			
L. W. Schrank, Waupun	x	x	x
H. G. Bayley, Beaver Dam	x	o	o
Door-Kewaunee—			
J. G. Beck, Sturgeon Bay	x	x	x
E. W. Wits, Kewaunee	o	o	o
Douglas—			
C. J. Picard, Superior	x	x	x
R. P. Fruehauf, Superior	x	x	x
Eau Claire-Dunn-Pepin—			
O. G. Moland, Augusta	x	x	x
A. A. Drescher, Menomonie	x	x	x
I. L. Blose, Durand	x	x	x
D. R. Griffith, Eau Claire	o	o	o
Fond du Lac—			
D. J. Twohig, Jr., Fond du Lac	o	x	x
R. S. Pelton, Ripon	x	x	x
Forest—			
E. F. Castaldo, Laona	o	o	o
B. S. Rathert, Crandon	o	o	o
Grant—			
H. W. Carey, Lancaster	x	x	x
C. L. Steidinger, Platteville	o	o	o
Green—			
W. E. Hein, Brodhead	o	o	o
R. G. Zach, Monroe	x	x	x
Green Lake-Waushara—			
A. J. Wiesender, Berlin	x	x	x
A. T. Leininger, Green Lake	o	o	o
Iowa—			
W. P. Hamilton, Dodgeville	o	x	o
W. D. Hamlin, Mineral Point	x	x	o
Jefferson—			
R. W. Quandt, Jefferson	o	x	x
H. G. Mallow, Fort Atkinson	x	o	o
Juneau—			
M. S. Tverberg, Mauston	o	x	o
J. H. Vedner, Mauston	o	o	o
Kenosha—			
H. L. Schwartz, Kenosha	o	o	o
R. W. Ashley, Kenosha	x	x	x

First name is delegate, indented name is alternate.

La Crosse—

J. P. McCann, La Crosse	x	x	o
F. J. Gallagher, La Crosse	o	o	o
S. E. Sivertson, La Crosse	o	x	x
P. D. Anderson, La Crosse	o	o	o

Lafayette—

R. E. Oertley, Darlington	o	x	x
R. E. Hunter, Argyle	o	o	o
N. A. McGreane, Darlington	x	o	o

Langlade—

B. W. Beattie, Antigo	o	o	o
W. P. Curran, Antigo	x	x	x

Lincoln—

D. F. Jarvis, Tomahawk	x	x	x
W. E. Braun, Merrill	o	o	o

Manitowoc—

W. E. Acheson, Valders	o	x	x
N. A. Bonner, Manitowoc	x	x	o

Marathon—

E. P. Ludwig, Wausau	x	x	x
D. M. Green, Wausau	o	o	o

Marinette-Florence—

C. E. Koepp, Marinette	x	o	x
J. W. Boren, Jr., Marinette	x	x	o

Milwaukee—

F. E. Drew, Milwaukee	x	x	x
R. E. Callan, Milwaukee	o	o	o
W. J. Houghton, Milwaukee	x	x	o
G. J. Bergmann, Milwaukee	o	o	o
G. W. Hilliard, Milwaukee	x	x	x
W. J. Conen, Milwaukee	x	x	x
H. J. Lee, Milwaukee	x	x	x
J. M. Beffel, Milwaukee	o	o	o
G. E. Collentine, Jr., Milwaukee	x	x	x
R. A. Nimz, Milwaukee	x	x	o
J. F. Cary, Milwaukee	o	x	x
E. J. Schmidt, Milwaukee	x	x	o
B. J. Brewer, Milwaukee	x	o	o
H. C. High, Jr., Milwaukee (see specialty section)			
P. E. Oberbreckling, Milwaukee	x	x	x
A. A. Presti, Milwaukee	o	o	o
J. M. Sullivan, Milwaukee	x	x	x
R. H. Lillie, Milwaukee	o	o	o
R. W. Mann, Milwaukee	o	x	o
D. M. Ruch, Milwaukee	x	x	o
E. G. Collins, West Allis	o	x	x
R. H. Frederick, West Allis	o	o	o
J. W. Fons, Milwaukee	x	x	x
W. L. Coffey, Milwaukee	x	x	o
R. F. Purtell, Milwaukee	o	x	x
K. E. Sauter, Milwaukee	x	x	o
S. L. Chojnacki, Milwaukee	x	x	o
H. M. Klopf, Milwaukee	o	o	x
D. M. Willson, Milwaukee	x	x	x
S. E. Zawodny, Milwaukee	o	x	x
A. J. Sanfelippo, Milwaukee	x	x	x
E. D. Wilkinson, West Allis	x	x	o
Edgar End, Wauwatosa	x	x	x
L. R. Weinshel, Milwaukee	x	x	x
S. W. Hollenbeck, Milwaukee	o	x	x
B. J. Peters, Milwaukee	x	o	o
F. A. Ross, Milwaukee	x	x	x
J. P. Fetherston, Jr., Milwaukee	o	o	x
C. M. Schroeder, Milwaukee	x	x	x
L. R. Schweiger, Milwaukee	o	o	o
V. L. Baker, Milwaukee	o	x	x
R. T. Sproule, Milwaukee	x	x	x
H. F. Twelmeyer, Milwaukee	x	o	o
D. W. Calvy, Milwaukee	o	x	o
P. F. Hausmann, Milwaukee	o	o	o
Marvin Wells, Milwaukee	x	o	x

Monroe—

D. C. Beebe, Sparta	x	x	x
J. S. Allen, Norwalk	o	x	x

Oconto—

H. A. Aageson, Oconto	x	x	x
G. R. Sandgren, Suring	o	o	o

Oneida-Vilas—

Marvin Wright, Rhinelander	x	x	x
I. E. Schiek, Rhinelander	o	o	o

Outagamie—

George Behnke, Kaukauna	x	x	x
John Russell, Appleton	x	x	x

Pierce-St. Croix—

P. H. Gutzler, River Falls	x	x	x
O. H. Epley, New Richmond	o	o	o

Polk—

L. O. Simenstad, Osceola	x	x	x
R. M. Moore, Frederic	x	x	x

Portage—

F. E. Gehin, Stevens Point	x	x	x
W. A. Gramowski, Stevens Point	o	x	o

Price-Taylor—

W. W. Meyer, Medford	x	o	o
W. E. Niebauer, Phillips	o	o	o

Racine—

G. J. Schulz, Union Grove	x	x	x
F. M. Hilpert, Racine	x	x	x
R. W. Kreul, Racine	x	x	x
H. J. Barina, Racine	x	o	o

Richland—

D. J. Taft, Richland Center	o	o	x
R. E. Housner, Richland Center	x	x	o

Rock—

M. D. Davis, Milton	x	x	x
A. H. Twyman, Beloit	x	o	o
W. S. Freeman, Beloit	x	x	o
E. F. McNichols, Janesville	o	x	o

Rusk—

H. F. Pagel, Ladysmith	o	o	o
M. L. Whalen, Bruce	x	o	x

Sauk—

C. R. Pearson, Baraboo	x	x	x
E. V. Stadel, Reedsburg	o	o	o

Shawano—

H. C. Marsh, Shawano	o	x	x
D. A. Jeffries, Shawano	o	o	o

Sheboygan—

P. B. Mason, Sheboygan	x	x	x
F. A. Nause, Sheboygan	o	o	o

Trempealeau-Jackson-Buffalo—

B. C. Dockendorff, Arcadia	x	x	x
E. P. Rohde, Galesville	o	x	o

Vernon—

R. S. Hirsch, Viroqua	x	x	x
P. T. Bland, Westby	o	o	o

Walworth—

E. D. Sorenson, Elkhorn	x	x	x
J. E. Martin, Jr., Delavan	x	x	x

Washington-Ozaukee—

W. A. Nielsen, West Bend	x	x	x
J. F. Walsh, Port Washington	x	x	x

Waukesha—

Joseph Bartos, Waukesha	x	x	x
Aaron Sweed, Waukesha	o	o	o
J. F. Wilkinson, Oconomowoc	x	x	x
A. F. Rogers, Oconomowoc	x	o	o

Waupaca—

O. E. Larson, Clintonville	x	x	x
W. R. McInnis, Marion	o	x	x

Winnebago—

G. P. Schwei, Menasha	o	o	o
David Regan, Neenah	x	x	o
E. A. Strakosch, Oshkosh	x	x	x
W. V. Hahn, Oshkosh	x	x	o

Wood—

R. W. Mason, Marshfield	x	x	x
E. C. Glenn, Wisconsin Rapids	o	x	o

SECTION:

General Practice—

C. J. Picard, Superior	(see Douglas County)		
D. N. Goldstein, Kenosha	x	x	x

Internal Medicine—

L. J. Kurten, Racine	x	x	x
R. L. Gilbert, La Crosse	o	o	o

Neurology and Psychiatry—

E. C. Schmidt, Milwaukee	o	o	o
R. A. Jefferson, Milwaukee	o	o	o

Obstetrics and Gynecology—

R. E. Whitsitt, Madison	x	o	o
George Hank, Madison	x	x	x

Ophthalmology and Otolaryngology—

H. C. High, Jr., Milwaukee	x	x	o
George Nadeau, Green Bay	x	x	x

Orthopedics—

P. K. Odland, Janesville	o	o	o
M. W. Nelson, Racine	x	x	x

Pathology—

Gorton Ritchie, Milwaukee	x	x	x
E. A. Birge, Milwaukee	o	o	o

Pediatrics—

Sam Kohn, Milwaukee	o	o	o
Kenneth Winters, Wauwatosa	x	x	x

Public Health—

C. K. Kincaid, Madison	x	x	o
R. E. Graber, Chippewa Falls	x	o	x

Radiology—

W. T. Clark, Janesville	x	x	x
F. F. Golden, Madison	o	o	o

Surgery—

G. N. Gillett, Racine	x	x	x
J. D. Conway, Milwaukee	x	x	x

Urology—

J. W. Sargent, Milwaukee	x	x	x

Minutes of Special Council Meeting Madison, April 4, 1959

1. Call to Order and Roll Call

The Council was called to order by Doctor Fox, chairman, at 2:15 p.m. on Saturday, April 4, at Society headquarters in Madison.

Councilors present were Doctors Hill, Houghton, Dessloch, Blanchard, Kief, Fox, Bell, Conway, Galasinski (afternoon only), and Past President Kasten.

Officers and others: Doctors W. B. Hildebrand, president; F. L. Weston, treasurer; W. D. Stovall, AMA delegate; and A. A. Quisling, chairman, Committee on Public Policy (afternoon only).

Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Toser, Reynolds, Murphy, and Gavin; Mrs. Anderson; Miss Pyre.

2. Purpose of Meeting

Doctor Fox announced that the meeting had been called on short notice for the primary purpose of discussing some major legislative problems. Also, several podiatrists would be present to discuss the Council's statement on associations with ancillary personnel.

3. Joint Resolution 42, A.

This calls for a special study of the "administration of hospitals and the alleged unfair and inequitable charges imposed on the public in some cases." The Council was aware that independent studies of the costs of hospitalization were being conducted, one having been initiated by the Society itself through an appropriation to its Foundation. Legislative counsel advised that introduction of a bill to regulate Blue Cross and Blue Shield was anticipated, and it might be that this would take precedence over the joint resolution. Following discussion, it was concluded that no position be taken on the latter for the present, although, if it is advanced, the medical profession might become interested in it.

4. Bill 347, A.

This would eliminate the present immunity of nonprofit hospitals for the wrongful conduct of employees, and provide a maximum recovery of $25,000. Examples were given of how this bill, if enacted, could measurably increase the costs of hospitalization, and for that reason among others it was recommended that the Society oppose the bill.

On motion of Doctor Dessloch, seconded and carried, the Council agreed that the bill be opposed in manner determined by legislative counsel.

5. University Hospitals

The Secretary told the Council of a recent meeting at the Society between the Board of Regents, University administrators and medical school representatives, and, because of a snowstorm, only local members of the Committee on Coordination of Medical Service. Under discussion were the shortage of clinical teaching patients and the operating deficit of the hospital, which were also of current concern in the Wisconsin Legislature. Subsequently, the Governor had announced that a survey of these problems would be conducted by University and medical school authorities, the State Department of Public Welfare, and the State Medical Society.

The Council recognized the importance of the problem to medical education, requiring the cooperation of all members, and on motion of Doctors Galasinski–Kasten, carried, asked that its Scientific Committee again participate, as it had in 1958, in future meetings to attempt to find workable solutions.

6. Podiatry—Special Order

Dr. E. C. Meldman and two other members of the Medical Relations Committee of the Wisconsin Society of Podiatrists appeared to discuss their objections to and problems created by the Council's "Statement of Ethical Principles" adopted in 1958 and previously recorded in its minutes. The statement concerns the ethical aspects of physicians indicating association with ancillary personnel of limited training and skills.

In essence, the podiatrists maintained that this had caused concern for those, admittedly few, who had been sharing space with physicians; but more than that, they felt it placed a "stigma" on them,

when all they wanted was to continue practicing podiatry within the statutory limitations. They believed that podiatrists should be excluded from the statement as dentists are.

The Council questioned them concerning their education and scope of practice, and in conclusion, advised them that it would not take action at that time. Later, the Council agreed that the question be referred to a group of orthopedists for study and advice.

7. Bill 129, A., Hospitals and the Practice of Medicine; Bill 485, A., SMS Authority to Write Hospital Coverage; Rogan Report

The status of these bills was discussed until dinner recess, following which these actions were taken:

On motion of Doctor Conway, seconded and carried, the Secretary was asked to arrange a meeting at the earliest practicable time of the Public Policy Committee, President, Chairman of the Council, with special representatives and attorneys, preliminary to a further meeting with Wisconsin Hospital Association representatives.

On motion of Doctors Dessloch–Hill, the Secretary was authorized to terminate committee activity of non-emergency character until the end of May.

Without formal action, the Council confirmed in the secretary administrative discretion to suspend the budget for future review (perhaps in July) and probable necessary revision in light of time and expense involved in many unusual activities.

On motion of Doctors Hill–Blanchard, carried, the Council authorized the retaining of public relations counsel, and a visit to the Iowa State Medical Society by several Wisconsin Society representatives.

On motion of Doctors Kief–Hill, carried, the Council approved reproduction and distribution of the Rogan Report accompanied by a letter from Doctor Fox which would call attention to the fact that the report, suggesting adequate insurance department supervision of the "Blue Plans," points up "the main issue of who is going to control the practice of medicine—the physicians or the hospitals." This motion also authorized public release of the Society position.

8. Erwin C. Cary, M.D.

Doctor Hildebrand transmitted the request of the Manitowoc County Medical Society for honorary membership for Doctor Cary.

On motion of Doctors Dessloch–Hill, carried, the Council elected Erwin C. Cary, M.D., Reedsville, to honorary membership in the Society.

9. Resolutions

For information of the Council the Secretary summarized the five resolutions which had been filed for consideration by the House of Delegates at the 1959 annual meeting.

Mr. Murphy was questioned concerning the interpretation of the Society's Constitution and Bylaws by the Manitowoc County Medical Society in its resolution which concluded that Chapter XXXVI, Section 8 of the Bylaws, providing that the Secretary of the Society need not be a physician nor a member of the Society, was unconstitutional. After discussing the provisions involved, and the general corporation law which also has application, no inconsistency was found between the Constitution and Bylaws on the point raised by the resolution.

On motion of Doctors Kasten–Houghton, carried, the Council asked that this resolution be transmitted to the House by Doctor Fox with appropriate legal comments.

10. Bill 3, S.

The Secretary reported that some misunderstandings had developed among the parties interested in the creation of a treatment center for emotionally disturbed children, with reference to the physical facility and its medical direction. Presentations to the Legislature had become confused to the point that Doctor Bowers for the Medical School, Mr. Schmidt for the State Department of Public Welfare, and Mr. Crownhart had administratively issued a joint statement listing these points of mutual agreement:

1. Wisconsin is in urgent need of an intensive treatment center for children whose emotional disturbance is such that no existing facility can cope with their problems. A treatment center is a top priority mental health need in this state.
2. The nature of these children and their problems requires the construction of a separate facility. Initially, the center should consist of 30 beds.
3. The center should operate under the general jurisdiction of the State Department of Public Welfare. In light of its important training and research potentials, however, the medical director and professional staff should be appointed by the director of the Department of Public Welfare upon the recommendation of the Dean of the University of Wisconsin Medical School.
4. The center will achieve its purpose only if it functions as a combined treatment-research-training unit. This means that it should be developed in a setting reasonably available to the Medical School and the Diagnostic Center so that it may be directly identified with the presently on-going residency training programs of the Medical School and the Public Welfare Department.

The following amendment to the bill was also recommended: "The professional medical staff shall be appointed by the director upon the recommendation of the Dean of the University of Wisconsin Medical School. The department is authorized to appoint such other staff as is required to operate such facility.

In discussion, Doctor Fox reminded the Council that it had in 1958 approved the principle of a treatment center which might also be used for teaching and research purposes. The Council agreed that it need not take any further action.

11. Milwaukee County Liaison Committee

Doctor Hildebrand told the Council of a letter he had just received from Doctor Devitt requesting a "transcript of the minutes of the Council meeting which approved this committee; also . . . a clearly defined statement, outlining the purposes of this committee, the extent of its authority to act or recommend, and the scope of its proposed field of inquiry." Doctor Hildebrand wished action on this request. On motion of Doctors Bell–Hill, carried, the Council advised Doctor Hildebrand to transmit the motion adopted in executive session at the last meeting.

12. Council's Report to the House

There was general agreement that the Council's report, not yet drafted, could be cleared with the Executive Committee prior to distribution.

13. Century Plan

There was filed with the Council an outline of the benefits to be offered persons 65 years of age and over, effective May 1, 1959. The Council was advised that the plan would not be advertised in Milwaukee County, but it was felt that if applications were received, they should be accepted at least until such time as Surgical Care has a plan under which it wishes to take them over.

14. Petition of Ozaukee County Members

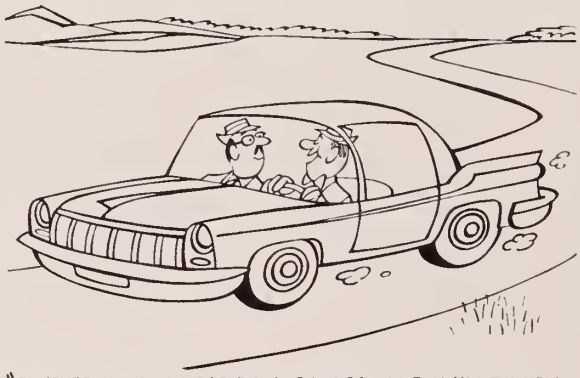
On motion of Doctors Dessloch–Bell, carried, the Council recommended approval of the House of Delegates to the petition of Ozaukee County members of the Washington–Ozaukee County Medical Society to form a separate county society.

15. Adjournment

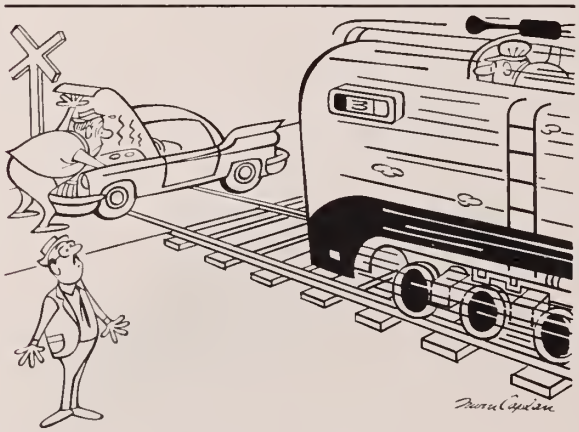
The Council adjourned at 9:00 p.m., Saturday, April 4, 1959.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M.D.
Chairman of the Council



"I NEVER TAKE MY CAR TO A GARAGE...THE MINUTE THEY START GIVING ME TROUBLE I TRADE 'EM IN ON A NEW ONE."



KEEP YOUR CAR IN GOOD REPAIR, BUT DEPEND ON CARE TO GET YOU THERE

Vehicles *in apparently good condition* accounted for 94.4% of all the vehicles involved in fatal accidents in 1958. These same type of vehicles were involved in 95.5% of all nonfatal accidents. Other types of vehicles involved in the remaining percentages of accidents had defective brakes, defective steering, 1 or 2 lights out, tail light out or obscured, other defects in equipment, a puncture or blowout.

INFORMATION COMPILED FROM *THE LUCKLESS LEGION*, PUBLISHED BY THE TRAVELERS INSURANCE COMPANIES, HARTFORD CONNECTICUT

THE MEDICAL FORUM

STATE AFFAIRS

LEGISLATION

Final Roundup

Wisconsin legislators, thin-lipped and tired, adjourned late last month after the longest regular session since 1943.

By all accounts it had been one of the most hectic sessions on record, and, actually, it was not over yet: the two houses had merely suspended operations, would return on Nov. 2, principally to solve the state's pressing fiscal problems. (There is an agreed-upon agenda, including some health bills laid over; no new bills may be introduced.)

In toting up the pluses and minuses, remembering always that politics is still "the art of the *possible*", it could be said that Wisconsin had had a highly successful session for public health and medicine. Some examples:

PASSED

Bill 129,A.—Prohibiting fee splitting between hospitals and physicians, prohibiting hospitals from hiring doctors and retailing their services at profit; permitting contracts between hospitals and physicians under certain conditions, and billing by the hospital as agent for the physician. SMS and hospital association agreed on final bill after long negotiations.

Bill 420,A.—Outlawing shoe x-ray machines because of dangerous side radiation. SMS supported.

Bill 907,A.—Giving state insurance commissioner authority to regulate Blue Cross, Surgical Care and WPS equally. (WPS had already complied voluntarily in most respects.) SMS supported.

Bill 3,S.—Creating a treatment center for emotionally disturbed children. SMS supported.

Bill 178,S.—Permitting graduating medical students to be examined for license to practice immediately after graduation rather than waiting until internship is finished. Speeds up process of getting into practice. SMS supported.

KILLED

Bill 133,A.—Requiring an employer to provide chiropractic treatment at his expense for workmen's compensation or illness. Opposed by SMS.

Bill 353, A.—Expanding scope of optometry practice. Opposed by SMS.

Bill 416,A.—Licensing naturopaths . . . "nature healing quacks." Opposed by SMS.

Bill 485,A.—Prohibiting WPS from selling hospital insurance. This bill was withdrawn by its authors just before the session ended, rather than defeated. Opposed by SMS.

LAID OVER

Bill to register psychologists (SMS opposes) and another to register opticians (SMS favors) were laid over for consideration when Legislature reconvenes in November.

Another bill calling upon the Legislative Council to study means of providing better local public health department organization in Wisconsin was approved. This had SMS support. The Council will make its report to the Legislature at the 1961 session.

A GIFT TO SMS from Parke, Davis & Co. are framed, four-color reproductions of their famous paintings, *The History of Medicine*. "We are highly complimented by your desire to give them a permanent place . . ." said Carl Johnson, P-D vice president. The series, now hanging in the SMS dining room, depicts medicine across five continents and fifty centuries.

Council Acts!

CARE OF THE AGING*

The subject of adequate safeguards in the care and protection of our senior citizens is being brought into sharp focus in the next several years. State and regional conferences will precede a Presidential Conference in 1961.

The facets of this matter are many, but those which hold the most public attention are adequate facilities for domiciliary care and the health needs of these deserving people.

A great deal has already been accomplished, particularly so in Wisconsin.

Laws relating to the establishment, conduct and regulation of nursing homes in Wisconsin are administered by the State Board of Health.

Some insurance organizations are offering good programs of prepaid health care.

Civic leaders in many areas of Wisconsin are directing local efforts to ascertain and alleviate problems encountered in local areas.

The Council of the State Medical Society believes, however, that much more can be accomplished and long-range planning will be more realistic if there is developed a centralized source of information with adequate facilities for research and reporting.

Such a facility should be state-wide, have official standing, and be adequately financed. While this might be accomplished through existing voluntary organizations, its optimum efficiency will ultimately demand the official interest of the state.

Senior citizens deserve all the privileges they enjoyed during their more productive economic years. Among these are freedom of choice of their medical care and hospital facilities; the ability to purchase and retain insurance against unanticipated costs of health care; retention of the right of privacy; and above all, preservation of their dignity and their constitutional guarantees.

It is upon these and other considerations that the Council:

(1) Requests each county medical society to establish a committee on care of the aging, such committee to act in cooperative effort with the State Medical Society's committee now in existence and functioning.

(2) Asks that such county society committees be organized by early fall of this year.

(3) Suggests that each committee inform itself, its county society and the State Society on facilities within the area of the county or counties for which the Society is organized, and include within its survey such matters as costs, public health safeguards, free choice of medical and hospital facilities, and needed coordination of local efforts.

(4) Invites the State Board of Health to conduct an early study of its structure to the point that it determine the feasibility of creating a division especially assigned to coordination of studies, research and recommendations as to present and potential needs of Wisconsin's senior citizens.

(5) Asks those organizations providing senior citizens with prepaid plans of health care to develop a method for pooling their experience, that for the good of all, these programs be extended and improved as knowledge is gained in this area of economic effort.

Such pooled information will be of excellent assistance to such studies as that of the School of Commerce, University of Wisconsin, now being conducted with financing from Wisconsin Physicians Service of the State Medical Society.

(6) Invites each member of the State Medical Society, and others with particular responsibilities and concern for the senior citizen, including doctors of dentistry, nurses, pharmacists, hospital administrators and their boards of trustees, and others to join in this total coordinated program . . .

All in recognition that youth, maturity and seniority in citizenship are each component elements of a strong democracy, and Wisconsin, always a state to pioneer, will again be one to lead the way in constructive and realistic programs of essential public welfare.

* Statement adopted by the Council of the State Medical Society of Wisconsin, July 25, 1959.

STATE AFFAIRS

COUNCIL

Forand Bill

Meeting in Land O'Lakes last month, the SMS Council took a long look at the Forand Bill (H.R. 4700) whose hearings had just been concluded.

"It is evident that neither the nation's welfare nor the health of the aged adequately will be served by legislation to provide surgical-medical-hospital and nursing home care through the mechanism of the Social Security Act," said the Council.

Council reasoning: ". . . the individual would suffer both as citizen and patient . . . be discouraged from providence and family responsibility . . . his free choice of physician would be markedly reduced, and the personal relationship with his physician severely handicapped."

On the cost: "The nation's economy would reel under the initial cost and the completely unpredictable financial burden of the future . . . acceptance is an invitation to expansion . . . voluntary efforts . . . would be completely discouraged . . ."

Council conclusion: "The Society must oppose such legislation . . . Certainly medicine's initiative and imagination can be tapped again and again for new and revised methods of assuring adequate health care for all the aged who need it."

CANCER

McArdle Funds Sought

Congressman Melvin R. Laird (R–Marshfield) has introduced a bill authorizing $2.5 million for additional cancer research facilities at McArdle Memorial Institutes, University of Wisconsin. No "matching" funds would be required.

The bill, which also carries authorization for another $27.5 million in construction for cancer and heart research facilities in 14 additional locations, was introduced by Laird because of a letter to him from Dr. H. P. Rusch, director of McArdle.

"The need for more space for research in this country should be met before funds are provided for support of research abroad," wrote Dr. Rusch. His position was backed by University President Conrad A. Elvehjem and Dr. John Z. Bowers, Dean of the Medical School.

Laird, whom Washington newsmen are labeling as the Congressional specialist in medical appropriations, pointed out that his bill is merely an "authorization", does not actually carry a fund appropriation.

But he said he hoped to incorporate the measure in next year's Health, Education and Welfare Department money bill.

Laird is a member of the House subcommittee which will handle the bill.

LESS THAN A WEEK after the Council declaration on the opposite page, SMS had swung into action with a meeting on the aged attended by representatives of medicine, dentistry, hospitals, nursing home operators. Taking charge was Dr. A. M. Hutter, Fond du Lac, (center), chairman of SMS Division on Aging. Others who participated are pictured above (left to right): D. C. Reynolds and T. J. Doran, of the SMS staff; H. O. Hoppe, D.D.S., S. D. Kelley, D.D.S., and C. M. Wilcox, D.D.S., of the Wisconsin State Dental Society; E. R. Thayer, of the SMS staff; Doctor Hutter; Msgr. E. J. Goebel and N. E. Hanshus, of the Wisconsin Hospital Association; Mrs. Pearl Dawson and Elmer C. Kocovsky, M.D., of the Wisconsin Association of Nursing Homes, Inc.; and G. G. Stebbins, M.D., of the SMS Division on Aging.

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STATE AFFAIRS

TETANUS

Warning

Late last month Dr. William B. Hildebrand, SMS president, issued a public statement, warning that "tetanus protection through immunization is an absolute must for public safety".

He called attention to three recent cases of lockjaw in the Manitowoc-Sheboygan area.

Although all victims are said to be recovering, Dr. Hildebrand stated, even with proper treatment, the State Board of Health estimates that 40–60% of those who contract this dread disease die, and it is an extremely painful death".

"Everyone should protect himself against lockjaw through immunization," he went on, "particularly vacationers." "Vacation injuries are commonplace, and tetanus germs are every place," he said.

Farmers, housewives who garden and industrial workers are most exposed to tetanus, cautioned Dr. Hildebrand.

"Even if death does not occur, treatment is tremendously costly in terms of man hours and wages lost, and workmen's compensation payments as a result of illness from serum reaction to tetanus antitoxin," he explained.

ANNUAL MEETING

1960 Program

The Council on Scientific Work, meeting in July, named Dr. M. C. F. Lindert, Milwaukee, as general program chairman for the 1960 Annual Meeting.

Several regular programs were shifted to provide a better balance of scientific material.

The first day, May 3, will begin with a "cardiac arrest" demonstration performed by Marquette and University of Wisconsin surgical teams on anesthetized dogs. Afternoon programs will include obstetrics and gynecology, pediatrics, internal medicine.

The second day will include morning and afternoon programs on general practice with specialty

DR. WILLIAM B. HILDEBRAND
"An absolute must . . ."

programs on pathology, urology and psychiatry.

Tuesday evening Wisconsin chest physicians will present a series of "fireside conferences."

It is anticipated that Mr. C. W. A. Falconer, Secretary of the Royal College of Surgeons and Professor of Surgery at the University of Edinburgh, will attend. If so, he will deliver the Beaumont lecture on Wednesday morning and another on Surgery on Thursday.

Thursday morning will feature a Dermatology Clinic. Afternoon programs include anesthesiology, otolaryngology and ophthalmology, radiology, surgery.

DR. M. C. F. LINDERT
. . . and a better balance.

The following assignments were also made for the ensuing year: Dr. M. F. Huth, Baraboo, General Chairman, Dr. Roy Larsen, Wausau, Round Table Chairman, Dr. Richard Farnsworth, Janesville, Scientific Exhibits, Dr. A. R. Curreri, Madison, Special Assignments, and Dr. George Collentine, Jr., Milwaukee, Host for Speakers.

MEDICAL CARE PLANS

Executive Appointments

Last December the Council authorized the Commission on Medical Care Plans to establish its own committee structure, a first phase in a plan for greater efficiency throughout the Commission itself.

The initial step has been taken by the creation of an Executive Committee composed of Dr. E. M. Dessloch, Prairie du Chien, chairman; Dr. Robert Krohn, Black River Falls, vice chairman; Dr. N. A. Hill, Madison, treasurer, and the following appointed members: Dr. D. N. Goldstein, Kenosha, Dr. Milton Finn, Superior, Dr. A. W. Hilker, Eau Claire, and Dr. P. B. Mason, Sheboygan.

The Executive Committee will review monthly the work being done by the administrative staff and the problems which must be considered by the Commission. Out of that study ultimately will come recommendations for other committees.

CHIROPRACTIC

American Legion Inspection

Chiropractic turned up in the ranks of the American Legion at its mid-July state convention, held in Kenosha.

Standing stiffly at attention was a spine-chilling resolution to support legislation permitting veterans to receive outpatient treatment by chiropractors on the same basis that medical treatment is authorized by law.

The resolution, after a stern inspection, was drummed out. But it was predictable that at the 1960 state parade of legionnaires the same nervy resolution would twist into formation again.

STATE AFFAIRS

ACCIDENTS

"The 400"

Late last month when the crack passenger streamliner "The 400", bound from Chicago to the Twin Cities, flung five cars down the side of a Knapp, Wis., bluff, it looked like a major catastrophe had struck.

On board were 209 passengers and 14 crewman, 110 of whom were riding the five derailed cars.

But part way down the hillside was a line of sturdy trees, and it was these which prevented the cars from careening dozens of feet below to busy highway 12.

Responding to an urgent call for help from the St. Croix county sheriff, doctors and ambulances sped to the scene from a 40-mile radius.

And for once in an accident, professional aid was on hand in numbers that were more than adequate. The injured (none seriously) were few. The pleas for help had turned out an over-abundance of ambulances.

Said Dr. G. M. Sargeant, Baldwin, one of at least ten physicians who rushed to the spot, "I never saw so many ambulances before." Within a short time, police were sending emergency vehicles back empty.

Many of the lightly injured were treated at the site, others routed to the Menomonie Memorial Hospital (it was closest), where some 40 were examined. Three went to the Baldwin Clinic, two of which had cuts and bruises. The third was not injured.

No one in such an accident is ever likely to forget it, or the comforting feeling of seeing so many offering so much help to so few.

POLIO

Worst Year?

The U. S. Public Health Service last month gave physicians something to worry about: indications are that we may be going through the worst polio year since the Salk vaccine was introduced in 1955.

The number of paralytic cases is almost *double* the total for the same period last year. USPHS released figures that showed the mounting incidence since the beginning of July. And reports coming in from the states indicated an even greater increase as August progressed.

The worst outbreak this year has been in the Des Moines, Iowa, area, right next door to us.

There have been considerable increases in several other states, notably Minnesota, Michigan and Indiana—all Wisconsin neighbors.

Why not ask each patient under 40 years as he comes through the door if he has had his polio shots. And have your vaccine right where he can see it. Then insist, if you must, that he have it then and there.

TRAFFIC SAFETY

Revealing Inspections

The need for additional aids, such as the SMS postage stamp proposal, to make the public more traffic-safety conscious was strongly revealed recently.

A report from the State Motor Vehicle Department outlined results of a one-week statewide automobile check that was made by the Wisconsin State Patrol.

In all, a total of 52,410 vehicles were compulsorily inspected in 70 counties, 197 cities and 29 towns.

During checks a shocking 14,409 (over 27%) five-day tickets were written, ordering correction of defects detected.

The most common violation was that of operating with "no stop light". Other most frequent defects (in order named): non-operating directional signals, burned-out taillight, defective handbrakes, burned-out headlights and defective mufflers. Some 19 different types of equipment defects were discovered.

Of all drivers stopped, 157 were arrested for operating without a valid driver's license or in violation of license restriction.

BLUE CROSS

Reorganization

Last month Blue Cross announced a reorganization of staff functions reportedly aimed "at increased efficiency and improved planning for future growth".

James T. Goodman, former director of the hospital affairs division, went into a newly created post covering internal legal matters, government relations and future planning. He will continue as coordinator for Health Insurance, Inc., a wholly owned Blue Cross subsidiary.

Another new post, embracing public relations, hospital-physician relations and personnel relations, went to David S. Neugent, former group enrollment manager.

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STATE AFFAIRS

MARCH OF MEDICINE

Anniversary

During the past ten years many an old faithful radio program has gone by the board as radio itself revitalized to fight the toughly competitive Big Eye.

But one program has stayed on Wisconsin radio faithfully year after year and shows no sign of weakening: the State Medical Society's highly successful *March of Medicine.*

This month, to the catchy strains of its theme song, "Semper Fidelis", the *March* celebrated its tenth anniversary under the command of parade marshall Dr. Robbert C. Parkin.

Actually the program had begun four years earlier with Dr. Llewellyn R. Cole. With Dr. Cole's death in January, 1949, air time went to canned AMA broadcasts, but these lacked the regional appeal. Listeners turned the dial, mail dropped to zero, stations to just 17.

When amiable Dr. Parkin took over in August, 1949, he broke away from the straight narrative style of the program, began experimenting with a "medical reporter" and a question-and-answer format.

Says Dr. Parkin: "This permitted the facts to be presented in a more clear manner, and the lay reporter asked questions that a regular listener might ask."

The experiment immediately caught on and station after station signed up for the public service series.

Today, after ten years, 48 Wisconsin stations (more than half the 95 total*) air the program once a week to an inestimable audience of hundreds of thousands. There is no known program like it in the U. S.

Listeners mail from the troubled, the hopeful, the ill and the curious is treated confidentially. "But since you can't practice medicine by radio, I answer them in a general way and always refer them back to their family physician," explains Dr. Parkin.

An assistant to the dean of the University of Wisconsin Medical School, Dr. Parkin finds that his weekly radio stint gives him a different kind of satisfaction.

"For me, it's a compensation for the inability as an administrator to deal directly with patients," he declares.

To the sponsoring doctors of Wisconsin the program means even more: it is a weekly entrance into the thoughts of their patients that could not otherwise be achieved.

* It would be impossible to add too many more stations, i.e. competition, network commitments, etc.

DR. ROBERT C. PARKIN
The hopeful, the ill and the curious.

NURSING

"Darned Nonsense"

Attorney General John W. Reynolds has ruled on that strange organization called the American Registry of Doctor's Nurses.

An employe in a doctor's office or clinic who wears the insignia of the ARDN without being a registered nurse is violating Wisconsin law, he said in an opinion last month.

An apparent commercial enterprise, headquartered in Washington, D. C., the ARDN has been soliciting members in Wisconsin. Members are given pins in the shape of a caduceus, on which the letters "D.N." are superimposed. They are also told they may use the letters after their names.

Membership, according to Reynolds, was open to anyone employed in a doctor's office or clinic who could qualify on at least 10 of "an unlimited number" of office procedures, including bookkeeping.

The only purpose of a person who was not a registered nurse "holding herself out as a 'DN' or 'doctor's nurse' would be to deceive the public, Reynolds stated.

Snapped the Green Bay *Press-Gazette* editorially: "D.N. means Darned Nonsense."

The SMS advises physicians to beware of the "D.N." promotions, urges their office personnel join the State Nurses Association or the Wisconsin Medical Assistants' Society.

WPS

Green Bay Enrolls

A handsome addition to WPS ranks came recently when the 1,000-some employees of the city of Green Bay enrolled in the Special Service hospital-medical-surgical plan.

News reports indicated that WPS was picked as the agency to handle the job because its policy offered the best benefits for the money ($15.32 a month). Altogether, 15 insurance companies submitted sealed bids. Bids were judged by a committee representing eleven city departments.

STATE AFFAIRS

EDUCATION

Nursing School Vacancies

The Wisconsin State Department of Nurses released a report that the majority of state schools of nursing have closed admissions to the 1959 classes.

However, many hopeful applicants send in multiple registrations, so a few schools now find it possible to consider a limited number of additional applications.

Inquiries should be referred to the following schools: Luther, Eau Claire; Mercy, Janesville; Holy Family, Manitowoc; Evangelical Deaconess, Milwaukee; Marquette University, Milwaukee; Mercy, Oshkosh; St. Mary's, Wausau.

IMMUNIZATION

Portage Program

Portage County Medical Society has become the first such unit to take notice of the House of Delegates' guide for immunization planning.

A special committee of the local society received informal approval of area school and health agencies to set up a program calling for:

1) Vigorous promotion by family physicians of immunization during an infant's first year.
2) A policy to encourage completion of immunity and booster shots before a child enters kindergarten.
3) A system of records maintained both in physicians' offices and the office of the city nurse.
4) A major survey to determine effectiveness of previous programs and needs to be met by new procedures.
5) Establishment of a schedule of specific hours at regular intervals at offices of individual physicians which patients may regard as "immunization time".

The final point is subject to the approval of the county society, but members of the medical committee indicated that, barring difficulty, it was likely to become a part of the general program.

The Stevens Point *Journal* found both good and bad points in the plan.

Said the *Journal* editorially, "The promise that immunization will be denied to no one because of inability to pay leaves something to be desired." The weakness, felt the editors, stems from the fact that welfare cases will be "understandably reluctant . . . to admit economic hardship."

The *Journal* also asked for a uniform fee for all immunizations. "Charging a uniform fee for a service performed in the public interest would have the virtue of treating everyone alike . . . a wholesome effect . . ."

POISON CONTROL

Madison

ALpine 6–6811, University Hospitals Poison Information Center, Madison.

Milwaukee

DIvision 4–7100, Poison Control Center, Children's Hospital, Milwaukee

Kenosha

OLympic 4–5311, Poison Information Center, Kenosha Hospital, Kenosha.

EDUCATION

Medical Assts. Scholarships

Working medical assistants in both Dane and Waukesha counties are getting behind the new medical assistant's course which begins in September at Milwaukee Institute of Technology.

Both local groups are providing, out of limited resources, small scholarships.

The Dane County Medical Assistants Society offered a scholarship covering two years, received six applicants, picked Miss Patricia Tiedeman, Madison.

Based on desire, need and high school grades (upper third of class), the scholarship runs $25 a quarter for a total of $100 in two years. This virtually covers all fees and textbooks. Biggest stopper: room and board in expensive Milwaukee.

Indications are that the course, limited to 30, will be filled by start of school.

GREEN LAKE–WAUSHARA

Heart Clinic

A rheumatic fever and congenital heart disease clinic was held recently at Berlin Memorial Hospital.

Sponsoring the event were the Medical societies of Green Lake and the Wisconsin Heart Association. Such clinics are also a part of a plan devised by the SMS Division on Handicapped Children, and the State Departments of Public Instruction.

At Berlin, Drs. William J. Gallen and Lucille B. Glicklich, both of the Milwaukee Children's Hospital, examined 25 patients who were referred by their physicians.

Persons up to the age of 20 suspected of having heart diseases were eligible. In all cases, the patient's physician was notified of the findings.

EXAMINATIONS

Professional Nurses

An examination for professional nurses will be given by the Wisconsin State Department of Nurses, Sept. 28, 29, 30 and Oct. 1.

Applications should be filed by Sept. 6 with Adele G. Stahl, R.N., secretary of the committee of examiners for professional nurses, Room 607, 119 Monona Ave., Madison.

GP

Convention

Over 500 family doctors are expected to attend the 11th annual scientific assembly of the Wisconsin Academy of General Practice in Milwaukee Sept. 20–22.

Headquarters for the meeting will be the Plankinton Hotel, with all scientific sessions in the Milwaukee Auditorium. Twelve hours of category one credit have been approved by the AAGP.

Dr. Charles Picard, Superior, is the incoming president of the GP Academy, succeeding Dr. David N. Goldstein, Kenosha.

PRESS

"First, I Want Health"

As could be expected, during the hearings on the controversial Forand Bill before Congress some of the state press printed a rash of letters generally condemning physicians, their bills, and upholding the idea of semi-socialized medicine (if that's possible). The following letter, appearing in the July 13th issue of the Milwaukee Journal, seemed to be the lone exception:

"To The Journal: In response to the letter, "Doctor Bills Too High," let me say I'm not a doctor nor a doctor's wife but I'm the mother of two small children and I'd like to ask the following question:

"What in this world is worth having that isn't high priced and what is more valuable than good health?

"Pleasures and luxuries of life—in fact, life itself—can't be enjoyed without first having health. I've been under a specialist's care for some time. I pay $5 for each office call and $12 for each prescription but I'm being restored to normal health because a young man (or his parents) spent thousands of dollars on seven years of medical education (probably more than seven for a specialist). And then there's an office to equip. Just price some of the equipment!

"With little education and no expense for equipment, many men and women are earning as much as the doctor. Think of the ballplayers and the Hollywood stars, many with nothing more than a high school diploma! And, wow, what salaries they get, just because you support them!

"There are some doctors who are money hungry and who take advantage of us. But you find a few such men in all walks of life, so why put all doctors in that class?

"A good doctor keeps up with medical advances in order to give us the best that science has to offer. Sure, I'll admit it knocks a hole in my budget when the doctor bill arrives. But I can't understand why some people say the doctor will have to wait because a time payment is coming due on a new freezer, a car, a TV set or a similar 'must' bill. Get sick at night and you'll not want to wait.

"To a good doctor, I'm not a gall bladder, an ulcer or a broken arm. He is one in whom I can confide, whether it's financial or family or health problem. And I will thank God that He created him with what it takes to be a doctor."

Mrs. R. H.

West Allis, Wis.

MEDICAL WORLD

TAXES

Break for Medical Clinics?

A federal district judge ruled at Dallas, Tex., late last month that medical clinic associations are taxable as corporations, not as partnerships.

This decision, if upheld, could have a sweeping effect in Wisconsin with its multitude of medical clinics.

The precedent-setting income tax case would apply not only to physicians, but to others such as lawyers, architects who sell their personal services.

At present, it is estimated that most medical clinics in Wisconsin are organized as partnerships. If the Texas judge's decision is upheld in the appeals courts, these partnerships could reorganize as associations. This would bring them under all the advantageous corporation tax laws. As corporations they could obtain major benefits such as deferred income pension plans. The money put into these pension plans would not be subject to income taxation until the benefits are paid after retirement.

The four-year-old case, climaxing last month, was built on the argument of Dr. Sidney Galt of a Texas clinic that doctors belonging to a partnership should be taxed only on salaries and bonuses paid them, not on association benefits. He said the undistributed profits should be taxed just like those of a corporation.

Government attorneys said the Internal Revenue Service had not decided on whether to appeal.

PRESS

LIFE Series

In September, *Life* magazine will launch a special four part story on the physician and modern medicine.

The series will cover: 1) the supply: physicians and patients; 2) the internist and general practitioner; 3) the surgeon; 4) medical care costs.

NUTRITION

Cows & Calcium

Nutritionists have come up with a figure that could only make Wisconsin dairymen happy at the prospect. It was estimated that a 9% increase in milk production would be needed if U. S. families were to have their recommended allowances in calcium. Grand total needed: 130 billion pounds of milk.

AGING

The Summing Up

Every adult shrinks about half an inch every 20 years, so said *Family Doctor*, a British medical weekly, in a recent issue.

Discussing the question of aging, it stated that many experts believed one day people would live to the age of 150. Research shows that the organs and tissues are capable of lasting more than 100 years if not damaged by diseases which medicine now is mastering.

The publication listed some of the known effects of aging: At 10, loss of elasticity in the eyes begins; at 20, hearing begins to fall off; at 40, the ability to see dimly lit objects starts to diminish; at 50, a decline in the finer degrees of tastes; at 60, the sense of smell begins to lose acuteness.

Summing it up, said *Family Doctor*, at 70, a man has lost two-thirds of his powers.

THE WISCONSIN MEDICAL JOURNAL

Volume 58 SEPTEMBER 1959 Number 9

Pheochromocytoma Associated with Von Recklinghausen's Disease*

By V. G. GUENTHER, M. D.

Oshkosh, Wisconsin

WHILE PHEOCHROMOCYTOMA can no longer be regarded as a rare disease, it is sufficiently unusual to excite more than passing interest in a small community. Summaries of reported cases by Smithwick *et al.* in 1950[1] and Graham in 1951[2] each listed 207 cases reported in the literature. Presumably based on Smithwick's figure of 5 cases found during adrenal exploration of 1,000 patients at sympathectomy, Newton *et al.*[3] have estimated that 800 deaths occur annually due to this neoplasm. While credit for the first clinical report is given to Labbe *et al.* in 1922,[4] its recognition in autopsy material dates back to 1886.[5] Pincoffs[6] is credited with making the first preoperative diagnosis in 1929.

Derived from the chromaffin system, these tumors, weighing up to 2,000 gm.,[7] are found chiefly in the right[1] adrenal gland. Ten per cent are bilateral.[8] The organ of Zuckerkandl is said to be the second most common site, then the sympathetic chain, with intracranial localization the least common. Women are found to have the disease more commonly, and attention is called to its occurrence in connection with pregnancy.[9] Forty-two cases have been reported in children.[10] The incidence of malignancy is extremely low; McGavack and co-workers[11] reported eight in 1942 and Mandeville *et al.*[12] added another in 1949.

The appearance of the tumors is characteristic. They are firm, discreet, often bluish in color, and frequently show hemorrhagic or other degeneration. The histologic pattern is monotonous; the large polyhedral cells have abundant cytoplasm and large, vesicular nuclei with prominent nucleoli. Stroma is scanty.

Chemically, they are known to contain epinephrine[13] and norepinephrine[14] in varying proportions. Hypertension has been reproduced by infusion of either or both of these agents experimentally. Clinically, the symptoms, including elevation of blood pressure, may be paroxysmal but are more frequently persistent;[15] although even in those with continuous hypertension, intermittent episodes of still higher pressures may occur.

The association of pheochromocytoma and von Recklinghausen's disease has been noted by Glushien *et al.*[16] who found 18 cases and added one of their own. At that time about 280 instances of chromaffinoma had been recorded. They quote Hollenhorst and Cahill as finding 10% and 20%, respectively, of their cases to be associated with neurofibromatosis. Glushien also called attention to one previous case of pheochromocytoma associated with Lindau–von Hippel disease (multiple hemangioblastomas and angiomatosis retinae et cerebelli) reported by Wold and Wilens in 1934, and added two of his own. He believes that there is more than a casual relationship between these types of ectodermal dysplasia and pheochromocytoma and predicts it may also be found in other members of the group, namely tuberous sclerosis and Sturge–Weber syndrome (encephalotrigeminal angiomatosis).

The most frequently reported symptoms are palpitation, pulsation in the abdomen, headache, sweats, anxiety, tremulousness, nausea and vomiting, heat intolerance. Paroxysms when present are often induced by

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change of posture, exertion, emotional disturbance or by massage or palpation of the abdomen. Attacks may last minutes to hours. Cerebral hemorrhage is the most common complication. Symptoms are frequently present for many years before their origin is suspected.

On examination, unless suspicion is aroused by evidence of abdominal tumor, said to be present in about 14%,[8] or some type neuro-ectodermal dysplasia, there is nothing about such a patient to distinguish him from normal if in a normotensive phase, or from one with essential hypertension. Temperature elevation is not a frequently reported finding, though Smithwick[1] states it may rise to 105 F. He also stresses vasomotor phenomena, postural hypotension and tachycardia, although these do not receive a great deal of attention in most case reports.

From the laboratory standpoint, much is still to be desired despite the many procedures now available. Elevation of the metabolic rate is sometimes noted, with normal protein-bound iodine and radioiodine uptake values. The blood sugar may be elevated and occasionally glycosuria may be present. Both of these tests are more frequently abnormal in patients with persistent hypertension.[17]

The chemical tests devised for the detection of pheochromocytoma are usually divided into two groups, those which reproduce an attack in persons who are found to be in a normotensive state and those which neutralize the effects of the pressor amines produced by the tumor and are thus utilized in the patients with presistent hypertension. Of the former group, histamine, first used by Roth and Kvale,[18] is unquestionably the safest and most reliable. The mode of action remains unknown. As with the other agents in this group, its effects must be compared with those of the cold pressor test of Hines and Brown.[19] The propensity of patients with latent or active hypertension to exhibit a rise in tension during the cold pressor test is well known. Smithwick[1] avers that one characteristic of pheochromocytoma is its failure to show this tendency. However, Orgain,[8] and Chapman and Singh[20] disagree, the latter quoting proven cases of pheochromocytoma among which 45% were hyper-reactors to the test. This group of drugs is employed when the blood pressure is below 170/110. Histamine base is used in the amount of 0.025 to 0.05 mg. injected rapidly intravenously. A blood pressure rise in from 1 to 4 minutes, maintained for up to 15 minutes, will occur in the presence of the tumor. Chapman and Singh suggest, as do most authors, a rise of 60 mm. systolic and 30 diastolic (in excess of the cold pressor response) as the criteria for a positive test. False negative tests usually are explained by the drug being injected too slowly or too high an initial pressure.[20] False positives are extremely rare, but have been reported, particularly when the patient has been receiving sedatives or potassium thiocyanate,[3] or if too large a dose of histamine is used.[8] An excessive rise is readily controlled by 5 mg. phentolamine methanesulfonate (Regitine) intravenously.

Methacholine chloride (Mecholyl), first used by Guarneri and Evans[21] and mentioned mainly to discourage its use since then, is given in a dose of 25 mg. subcutaneously. Both false positive and negative tests are frequent.

Tetraethylammonium salts, first used by LaDue, Murison and Pack,[22] are given in dosage of 300 to 400 mg. rapidly intravenously. Its advantage is the rapid control of hypertension by having the patient stand. However, false positive and negative tests are frequent[7,8] and its use is regarded as only supplementary.

Of the drugs used to lower sustained hypertension in the presence of chromaffinoma, piperoxan hydrochloride (Benodaine Hydrochloride), phentolamine, and dibenzyl betachlorethyl amine hydrochloride (Dibenamine) are used. In recent years phentolamine has come to be the most favored, partly because it is somewhat more reliable and perhaps more because it is the most pleasant to administer to the patient. Recently a case of an alarming pressor response to its use has been reported.[23] Its use was first described by Grimson *et al.*[24] in 1949, and afterward by Gifford, Roth and Kvale.[25] As with the other drugs of this group, a fall of 35 mm. systolic and 25 mm. diastolic pressure is considered significant. Five milligrams are injected rapidly intravenously, and a fall will usually occur in 2 to 4 minutes, be sustained 10 to 30 minutes. Newton *et al.*[3] report only one false negative in 1955. Such reactions are usually caused by the presence of uremia or the use of sedatives or hypotensive drugs, as are the more frequent false positive tests.

Piperoxan hydrochloride, first described by Fourneau and Bovet[26] and later by Goldenberg, Snyder and Aranow,[27] also will neu-

tralize in vivo the effects of artificially administered epinephrine (Adrenalin) or norepinephrine (Noradrenalin). The method by which any of these drugs achieves this neutralization is still obscure. It is given intravenously over a two-minute period in a dose of 0.25 mg./kilo. This drug is perhaps the most likely to produce hypertensive crises in patients with essential hypertension and, since it has no antidote, is dangerous. Its side effects are also objectionable. False positive and negative results are both fairly frequently reported, usually due to uremic states or the use of prior sedation or drugs aimed at the hypertension.

Dibenamine was first used by Spear and Griswald in 1948.[28] It is little used because its effects last 24 hours or more and false positive tests are frequent.

Of the methods used in identifying these tumors, it appears at this time that blood or urine assays of pressor amines may offer the most certain means at hand. Engel and von Euler[29] first performed urine assays in 1950. They reported no false results in over 500 patients. Levels 6 to 27 times normal were found in the presence of a tumor. The only objection to its use is the equipment required. It has been stated recently by von Euler and Ström[30] that this is the only certain method available. Elevated values are found even during normotensive states. More recently, however, Kvale *et al.*[17] describe false positive findings in patients with renal insufficiency, jaundice, increased intracranial pressure, lymphoma, and medication with epinephrine or other vasopressor drugs.

Corcoran, Duston and Page[31] have recently described a somewhat cumbersome test based on the fact that piperoxan hydrochloride will inhibit epinephrine-induced diuresis in patients with pheochromocytoma.

Report of Case

A 37-year-old white foundry worker presented himself with the complaint of epigastric distress of bloating character present for six years. An upper gastrointestinal x-ray study was negative then and again two years later. As time went on the symptoms became more frequent and the patient began to note a certain periodicity. Finally in the last three or four months they had become distinctly paroxysmal, recurring three to five times weekly. A typical attack would occur at work, begin with bloating in the epigastrium, followed by a pounding sensation there; there was associated weakness and trembling of the knees. After two to ten minutes the symptoms would subside entirely. Occasionally they would be brought on by lying on the left side in bed. There were no other associated symptoms.

He had lost 5 to 10 pounds in weight and was known to be emotionally tense and had numerous domestic problems.

Neurofibromatosis had been present since birth. In 1950 he had an operation for perforated diverticulum of the cecum.

The patient was a thin white male. He was afebrile; the blood pressure was 120/70. The abdomen was scaphoid, with no palpable tumor masses, tenderness, or hernia. Massage of the flanks produced no symptoms. The skin of the trunk and extremities was studded with innumerable soft neurofibromata. There were several areas of vitiligo of varying size.

Routine blood and urine studies were normal. A chest x-ray, electrocardiogram, and intravenous pyelogram were also within normal limits.

A cold pressor test revealed a rise in pressure from 80/60 to 90/60. Histamine base, 0.025 mg., was then given intravenously. The base pressure had been established at 120/70. Within 90 seconds this had risen to 270/170. In 2½ minutes it had subsided to 250/130 and at 5 minutes it was again 120/70. During this time the patient experienced a typical attack beginning with epigastric bloating and pulsating. In addition, a pounding headache developed, with nausea, great anxiety and later a moderate diaphoresis. Five minutes after the return of his blood pressure to normal he experienced a brief spontaneous attack identical to those he had been having in the past.

He was admitted to the hospital on January 24, 1957, and surgery performed on the next day. His blood pressure during induction of the anesthetic remained constant at 140/70 and did not rise during exploration of the right abdomen. On manipulation of the left side, it rose to 240/140 and subsided to 220/120 after injection of 5 mg. phentolamine, despite continued operation. When more direct pressure was exerted on the adrenal tumor, it rose again to 270/140 and was little influenced by another 5 mg. phentolamine. Shortly afterward the vessels were clamped and it fell precipitously to 120/70 where it remained during the rest of the surgery and during immediate and later con-

valescence. There was no need for any vasopressor substance at any time. Prior to his discharge on the eighth day, the histamine test was repeated with negative results.

Grossly the tumor was a firm, walnut-sized, dark blue mass which on section revealed a typical microscopic pattern of pheochromocytoma. There was no evidence of malignancy.

When last seen on July 18, 1958, the patient stated that he had been free of attacks, his appetite had returned and he had regained his loss of weight.

Discussion

The history presented by this patient was at first of very little assistance. Review of the presenting complaint on his two previous hospital records failed to reveal anything suggestive of a paroxysmal tendency. A diagnosis of functional gastrointestinal disease was made. It was not until the attacks became more frequent that any suspicion of pheochromocytoma was considered, and then it was largely because of the neurofibromatosis. He had never experienced headache, palpitation, flushing, or heat intolerance. Sweating was minimal and not volunteered in the history. It is considered fortunate that he was normotensive between episodes, since with a dose of 0.025 mg. histamine the response was so dramatic and so closely resembled the spontaneous attacks, there could be little doubt as to the presence of an active tumor. False positive tests with this drug, when used in the usual dose and in the absence of any prior therapy with sedation or hypotensive agents, are most rare.[21] In view of the rather obvious nature of the condition and the sudden death during diagnostic procedures on a patient with pheochromocytoma found unexpectedly here at autopsy in the past, no further studies were done. Kvale[17] points out that metabolic studies are of little aid in the paroxysmal type of disease. Facilities were not available for urine or blood assay of epinephrine or norepinephrine, and such assay on the resected specimen was not possible because of a laboratory accident. It was not felt that the small likelihood of success in localizing the tumor by air studies justified the danger involved.[1,3,30] Moreover, since the tumor may be bilateral in 20% of cases and a thorough search must be made for tumor tissue in both sympathetic chains and the organ of Zuckerkandl, the value of attempting localization must be considered dubious. While it has been said that one should be suspicious of remaining tumor tissue in those patients who do not require pressor agents for some time postoperatively,[3] we felt that a negative postoperative histamine test was reassuring. Moreover, this is not universally true, as noted in the patient reported by Grimson *et al.*, in whom phentolamine was used supportively during surgery for the first time.[6] No pressor agents were required postoperatively. This had been substantiated thus far by outpatient visits. The operative course left something to be desired. It is felt that the method of Newton *et al.*[3] would have produced a smoother course during manipulation of the tumor. These authors use 20 mg. phentolamine in 500 cc. of vehicle, given as a continuous intravenous drip, to be supplanted immediately after clamping of the vessels by *l*-norepinephrine (levophed) drip if needed.

It would appear that in maintaining a high index of suspicion for pheochromocytoma, it is necessary to keep it in mind not only in the routine evaluation of hypertensives, particularly in the thin or younger age groups and postpartum group, but also in any paroxysmal episodes usually considered to be emotional in origin. One should become especially alerted by the presence of neurofibromatosis.

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(continued on page 556)

William S. Middleton, M.D.

The Human Touch in Medicine*

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TO ME THIS IS a memorable and an arresting occasion. The Wisconsin Society of Internal Medicine has flaunted convention on several scores. In the first place, our Society has voted to initiate a lectureship named for a fellow member. Furthermore, this member is still living. Then, to complete the cycle of nonconformity, the named member has been invited to give the first lecture. If I appear to be speaking to myself, I know you will understand and will be indulgent. I am truly appreciative of the honor and distinction you, my friends, bestow upon me and I will discharge my responsibility to the best of my ability.

René Sand wrote that "the place of medicine is in the stream of life—not on its banks". In recent months many thoughtful people have been preoccupied with the development and the fate of earth satellites. For some time the Veterans Administration has been studying the application of electronic data processing to its operational and research activities. The analog and digital computers are being utilized to resolve some of the problems in spatial vectorcardiography. Conditioned by this background the invitation of International Business Machines, Inc. (IBM) to a private demonstration of a model of Vanguard by their experts was eagerly accepted. Absorbing as was the project for the exploration of space, my attention was diverted by a statement of one of our scientific guides, "Do not think me completely mad, Doctor, when I say that some day the electronic data processing machine will prove useful in answering questions in the diagnosis and the treatment of obscure clinical conditions".

The natural reaction of the clinician was "fanciful, visionary, preposterous". I parried, "Abrams had the same idea. One fed a few superficial facts into an electrical machine which returned the diagnosis and treatment". The physicist admitted that the data afforded the highly developed electronic data processing machine must perforce be accurate and tailored to meet the assumptions of an adequate answer. In other words, the product is determined by that which human intelligence supplies at the intake. Even granting the psychologic and the physiologic variables in a biologic subject he maintained that the objectivity of the procedure would one day determine its availability and utilization in clinical medicine.

This expert is not alone in his contention. Indeed, the literature on this phase of electronic data processing and its projection is growing. "And coming events cast their shadows before." (CAMPBELL) Electronic methods have, in fact, infiltrated widely in experimental and clinical medicine. They have, for example, replaced the silvered glass string in the electrocardiographic apparatus.

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It is no longer a string galvanometer. The phonocardiogram has reinforced auscultation of the heart. The cathode ray oscilloscope has broad applications in physiologic and clinical studies. The electron microscope extends the range of visibility 30,000 to 100,000 times. The expansion of the several branches of chemistry in their application to research and clinical medicine has been especially conspicuous. The spectrophotometer is indispensable in the routine laboratory. The flame photometer extends its range for the determination of sodium and potassium levels in the serum. The color strips in paper electrophoresis are resolved into an amazingly accurate curve by the analytrol. Colorimetric methods have been refined by electronic devices. Newer electronic developments now bid fair to replace the hemocytometer in blood counts. Extending the base, radioisotopes have come to occupy an assured place in medical research and practice. Labelled iodine, chromium, cobalt, and iron have proved especially useful in diagnosis. Radioisotopes of iodine, gold, and phosphorus have recognized therapeutic positions in the modern practice of medicine.

"Keeping an open mind is like keeping an open mouth. Sometimes you have to shut it in order to chew and survive." (CHESTERTON)

Out of the mechanization of certain phases of medical practice has grown the natural suggestion that its basic evaluation might be accomplished by appropriate mathematical means. Yet recent efforts to assess the quality of medical care solely on objective criteria have fallen far short of their mark. The clinical records have regularly been utilized as source materials. The adequacy of histories and physical examinations, intelligent utilization of laboratories, diagnostic accuracy, therapeutic and operative results, complications and mortality figures have afforded much food for thought and projection. By common consent among students of the subject, the medical audit remains an incomplete and inadequate instrument for the exact measurement of the actual care rendered the individual patient. With all the advantages of statistical methodology applied to modern medicine, this approach in the evaluation of the quality of medical care has proved incapable of general application. Its material contribution has been the stimulation of self-analysis. However wide may be the ultimate acceptance of its tenets, there is no prospect of the quantitation of the quality of medical care that can be universally applied to the individual patient.

The students of this important subject must look to the evolution of modern medicine for the explanation of this elusive circumstance. From the earliest accounts of medicine elemental fear of supernatural forces dominated the prevailing concepts of disease and its control. The propitiation of beneficent spirits was invited by votive offerings. Magic and amulets were invoked to fend the forces of evil. Medicine was subordinated to religion in India and Egypt. Greek culture separated these elements; but Hippocrates, the father of medicine, was an Asclepiad. The priests at the temple of Aesculapius enjoined the incubation sleep before administering to the sick and disabled. The inception of modern medicine, as currently recognized, may properly be dated from the French school of the late eighteenth and nineteenth centuries. Bichat emphasized the bedside-deadhouse correlation of disease manifestations as a most rewarding medium for the advancement of clinical knowledge. Corvisart, physician to Napoleon, revived the neglected *inventum novum* (percussion) of Auenbrugger. In his train followed a galaxy of Parisian clinical teachers who were to make this city the Mecca for curious-minded physicians from every quarter of the civilized world. Among these Laennec and Louis should be especially noted. Laennec invented the monaural stethoscope. By this epochal correlation of physical signs with necropsy findings he placed the diagnosis of pulmonary diseases on a firm basis for the first time. Louis evolved the numerical method in clinical practice. A symptom or a sign was significant in direct proportion to the frequence of its occurrence in a given disease. This principle is still generally applied in medical practice.

The leavening of the French School was early disseminated to Dublin, Edinburgh, London, Berlin, Vienna, Philadelphia, Boston, and New York. The intervening years have witnessed revolutionary changes in medical practice. As implied, morbid anatomy dominated medical thought for the early half of the last century. Indeed, Skoda, leader of the New Vienna School, considered few diagnoses clinched without a necropsy! The work of Virchow brought cellular pathology to the forefront, whereupon the microscopic definition of disease displaced gross

pathology in medical thinking. The pioneer efforts of Pasteur, Koch, and Lister gave substantial form to the science of bacteriology. Forthwith the etiologic diagnosis became the objective of clinical medicine. Time tempered this fixation; but the advent of the sulfonamides and the antimicrobial agents brought renewed attention to this significant aspect of human disease.

Meanwhile many other basic sciences, impinging on human life in health and disease, have grown apace. Particularly cogent in the present relation have been the developments in physiology and physiologic chemistry. Moreover medicine recognizes the increasing impact of psychology, genetics, anthropology, and sociology on the problems of health and disease. It may be truly claimed that the aim of modern medicine is holistic. As an unwholesome by-product of the highly technical support to clinical medicine, a certain impersonality in the patient-physician relationship confronts us. Several aspects of this problem emerge from a growing dependence on purely objective methods. Without detracting an iota from the importance of newer laboratory measures their very availability imposes a serious responsibility for intelligent, discriminating utilization. The so-called batteries of functional tests smack of shotgun rather than rifle fire on diagnostic target. Random probing in the feckless calls upon the laboratories for the whole gamut of examinations and tests without fixed direction is as devastating to the medical growth of the physician as it is to the effectiveness of the laboratory. With the temptation to lean inordinately upon this support comes a distinct trend toward scientific abstraction. Enmeshed in his scientific absorption the physician may overlook the fact that the object of his study is not merely the unhappy host of chemical aberrations, physiologic deviations, and electronic eccentricities but a human being seeking surcease from the psychologic as well as the physical traumata of disease and disability. In the patient's debilitated state of mind and body, an air of detachment on the part of the physician may perchance serve to erect an insuperable barrier to effective therapy.

"The secret of the care of the patient is in caring for the patient." (PEABODY) The potency of the laying on of hands is attested in the Holy Bible. "Then touched He their eyes, saying, 'According to your faith be it unto you' " (ST. MATTHEW IX, 29), was the Master's statement to the blind. Their sight was restored. Other references to healing by faith are encountered in the Bible. A recent account of the outstanding work of the Sisters of Maryknoll in Puson, Korea, depicts the simple faith of the natives. A moribund child was brought to the Clinic merely to be touched by a Sister. At least spiritual comfort was afforded the distraught parents. Particular interest in "Her Name is Mercy" stems from the fact that Sister Mercy is the sister of Dean John Hirschboeck. A graduate in medicine from Marquette University, her good works in many areas have redounded to the everlasting credit of her Alma Mater and to the glory of God.

Without ascribing divine power to the physicians, personal contact with the patient is admittedly an important factor in psychologic rapport. Not only will a painstaking history afford invaluable information to the physician but the patient will ordinarily gain composure and ease. The complete physical examination remains the most essential ingredient in the comprehensive study of the patient. By the physician's "quietly efficient thoroughness he will convey the comforting assurance of his interest and competence". (MIDDLETON) Yet, how often have you heard the patient say, "This is the first complete examination I have ever had"? So serious an indictment of medical practice must not be lightly treated nor condoned. It must be met by precept and example. Indeed, this thesis is one of the foundation stones of the American Society of Internal Medicine. By the same token, the very technique of the physical examination, conducted with precision and dignity, establishes a relationship between the patient and the physician unattainable by any other means. To digress for a moment, a careful inquiry leads to the conviction that the actual physical contact of the examination and the treatment(?) constitutes a major explanation for the defection of patients to osteopathy and chiropractic. Here the parallel ceases; but too little attention has been paid to this significant factor in medicine. Of course, beyond the psychologic significance of the physical examination comes the establishment of the presence or absence of morphologic and physiologic changes incident to disease.

The physician who denies to himself the information disclosed by the carefully elicited history and the meticulously conducted physical examination immediately sacrifices in-

sight and perspective. Certainly the inevitable impersonality of the patient-physician relationship under such circumstances must prove most prejudicial to successful cooperative therapy. As we have indicated, presently there is no prospect of resolving in a mathematical formula the actual quality of medical care to the individual patient. The objective criteria, now under consideration by the several agencies engaged in its study, are incapable of measuring the imponderable values of human sympathy and compassion. The output of the understanding heart of the true physician and the good nurse cannot be measured or approximated by any available method. Nonetheless this intangible force may be a vital, yes, a determining, factor in life and death.

"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."

— OSLER

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Fatal Fulminating Necrotizing Vasculitis in Steroid Treated Rheumatoid Arthritis*

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THE CASE HEREIN reported is, to our knowledge, the first one supported by autopsy in which death was due to diffuse fulminating necrotizing vasculitis resulting in fatal retroperitoneal hemorrhage from a ruptured subcapsular kidney arteriole in a patient on corticoid therapy for rheumatoid disease.

ACTH and the corticoids are being employed by physicians and surgeons for an increasing variety of conditions. Adverse side effects such as duodenal ulcer, a Cushing-like syndrome, glycosuria, osteoporosis, compression fractures, depression, suicide, precipitation of an occult diabetes, adrenal atrophy, and death from shock, have been observed. In the past year, rheumatologists have reported increasing incidence of polyneuritis and vasculitis with corticoid therapy. It, therefore, appears advisable to call the entire profession's attention to this more recent serious adverse effect of such therapy.

In the past 30 years there has been increasing pathologic and clinical interest in perineuritis associated with rheumatoid arthritis characterized by numbness, tingling, and sweating with neurologic signs supported by histopathologic changes in the peripheral nerves. Freund[1] in 1942 reported histologic perineuritis in 5 out of 11 cases studied and Morrison[2] in 1949 reported similar changes in 26 out of 31 cases at routine postmortem examinations.

Recent reports more often show an associated perineuritis as an accompaniment of steroid treated rheumatoid arthritis with clinical and pathologic evidence of polyarteritis. Robinson *et al.*[3] in 1953 described 4 such patients. Three of the 4 had received steroids and those 3 had more active arterial lesions. Kemper *et al.*[4] in 1957 reported perineuritis in 3 of the 4 rheumatoid patients who had received steroids. A postmortem examination of the fourth patient revealed a perineuritis not evident clinically. Irby *et al.*[5] in a two-year period observed 6 patients, with severe rheumatoid arthritis, who developed perineuritis. Of the 6 steroid-treated patients, 5 are still living and 1 died without autopsy. All had diffuse polyarteritis. They concluded that steriod therapy appears to play a positive role, and probably serves to activate a dormant vasculitis. Kemper *et al.*[4] reported on 52 postmortem examinations performed on rheumatoid arthritis patients who had died at Rochester. The overall vasculitis incidence in this series was 23%. The incidence of a widespread necrotizing arteritis was 8%. While the series was relatively small, in 4 (29%) of 14 patients receiving cortisone, widespread necrotizing arteritis was present. In 38 of the patients who received no adrenocortical hormones no lesions developed. They also report that in rheumatoid arthritis patients with chronic hypercortisonism, a "panmesenchymal reaction" appears resulting in a necrotizing arteritis and increased evidence of lupus erythematosus clot reactions. They suggest that this often fatal reaction follows withdrawal of hormones.

In the study of the patient herein reported we were impressed by the intensity of the pain and its diffuse nature which appeared to be more muscular and periarticular. The lack of morning stiffness and the subsidence of joint swelling did not appear to lessen this man's pain which he described on numerous occasions as muscular in the upper and lower extremities. At no time were subcutaneous hemorrhages noted. In retrospect, one might assume the pain to have been the result of the arteriolar perineural lesions and necrotizing arteries in the muscles. The pain in the flank a few hours before death was severe. At postmortem there were aneurysmal vascular dilations on the surface of the kidney, one of which had ruptured. This

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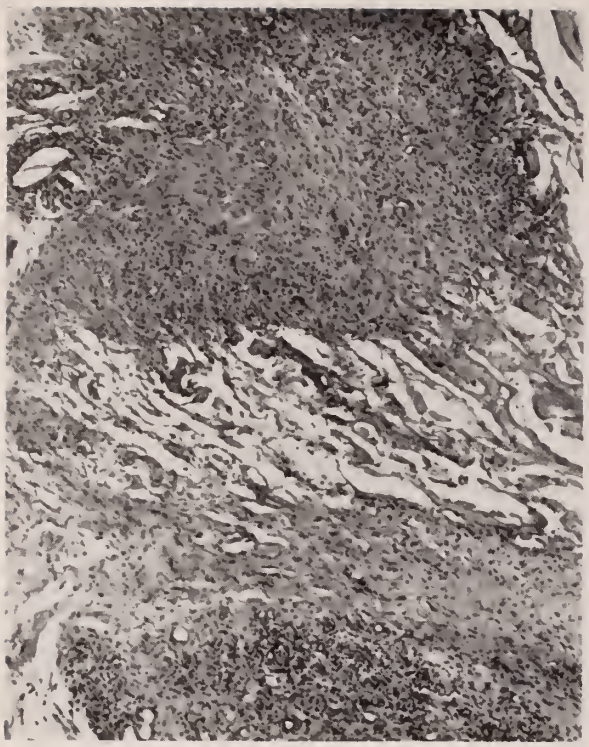

Fig. 1—Juxta-articular subcutaneous rheumatoid nodule. The central areas show fibrinoid degeneration and the outer margins contain fibroblasts, small capillaries, lymphacytes, and plasma cells. Hematoxylin and eosin: mag. X75.

flank pain could be explained on the basis of stretching of the vessel and the visceral peritoneum as the aneurysm expanded until it finally ruptured. In the reports thus far examined, this clinical aspect of pain has not been emphasized. It might lead the clinician to suspect the presence of a vasculitis.

Case Report

A white male, weighing 250 pounds, 75 inches tall, in February 1957, at 48 years of age, following the extraction of two loose teeth, complained of diffuse pain in his extremities. He was given an injection in both shoulders and an antibiotic. He seemed to improve but in a few months began to have more pain and received another shoulder injection. We first saw him four months after onset. He had been growing steadily worse and unable to work for two weeks. He appeared toxic with a migratory, very painful synovitis involving wrists, knees, ankles, shoulders, and the proximal interphalangeal joints of the fingers and toes. His white blood cell count was 13,950, sedimentation rate 21, hematocrit 52, fasting blood sugar 104 mg.%, uric acid 4.9 mg.%, C reactive protein 4 plus, and a slight degree of albuminuria.

Fig. 2—Left kidney. The ruptured, inflamed arteriole is indicated by the white arrow. On the exposed cut surface is a dilated and thrombosed arteriole.

He entered the hospital June 24, 1957, and remained there until July 30, 1957. Nodules had developed over the elbows which biopsy showed to be typical rheumatoid nodules. (Fig. 1). Prednisone, rest, physiotherapy, and salicylates brought about no improvement. ACTH, however, produced miraculous relief! After a single injection of 80 units, he was out of bed, walking about, amazed at the complete relief he experienced. He returned home on ACTH injections. Six days later gold therapy was begun.

On September 3, 1957, after six weeks gradual reduction in dosage, the ACTH was discontinued and prednisone was begun orally. He no longer complained of pain but tired easily. By September 25, 1957, he had received 290 mg. of a 50% gold solution. In December, he was having more very good days, less stiffness and soreness, and his weight had been reduced to 182 pounds. He walked with a cane. On January 1, 1958, he reported numbness in his feet, and the fingertips were sensitive and painful. Three weeks later he was seen by one of us (J.G.) who reported marked atrophy of the muscles

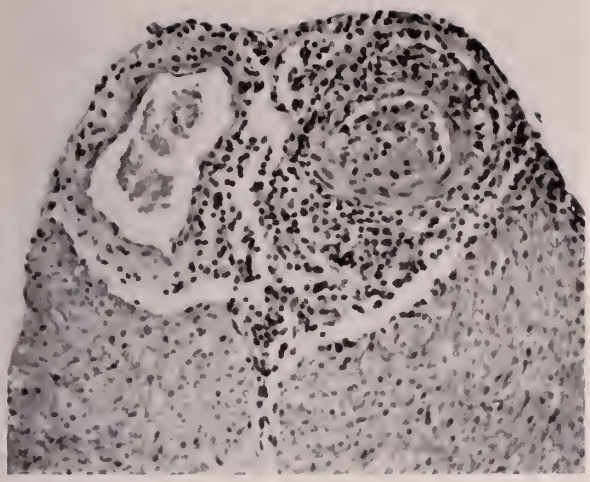

Fig. 3—Microscopic section of a peripheral nerve fascicle shawing an acutely inflamed arteriole beneath the perineurium. Hematoxylin and eosin: mag. X160.

of the upper and lower extremities and neurologic signs of a peripheral neuritis. Reexamination showed complete absence of swelling and soreness from his joints. There was some residual contraction of the right elbow, and slight thickening of the proximal interphalangeal joints of the fingers, a marked atrophy of the interossei muscles of the hands and the muscles of the lower extremities. The deep reflexes were absent in the knees and ankles, and there was bilateral foot drop.

He was readmitted to the hospital February 12, 1958. There was general wasting of all the muscle groups in the arms and legs. Electromyogram studies showed "a diffuse denervating process involving the upper and lower extremities. The presence of fibrosis and electrical silence in certain areas indicated an advanced state of the process." His hemoglobin was 14 gm., hematocrit 43, white blood cell count 21,450, with a normal differential count. The Latex precipitation test was positive. His oral temperature varied from 97.6 F. to 101.4 F.

On March 6, 1958, at 5:00 a.m. he complained of severe abdominal and left flank pain. His pulse rate was 120, blood pressure 90/60; he lost consciousness, his left pupil fixed in dilatation, and he expired in one-half hour.

Postmortem examination showed a generalized necrotizing angiitis, massive retroperitoneal hemorrhage secondary to rupture of involved arteriole in the left kidney (fig. 2) atrophy of muscles of the extremities secondary to involvement of nutrient arteries and the vessels of the spinal cord, (fig. 3) meningeal edema and congestion, and a peptic ulcer. The only organs spared of the vasculitis were the brain, lungs and spleen. Microscopically, "practically all of the small arteries and arterioles of the kidneys (fig. 4) showed advanced necrotizing angiitis characterized by fibrinoid necrosis, marked intimal proliferation and thickening, and fragmentation of the internal elastic membrane. There were aneurysmal dilatation and thrombosis of many of the involved arterioles; the ruptured necrotic subcapsular arteriole in the left kidney was surrounded by numerous foci of coagulation necrosis. Multiple areas of cortical scarring and mixed inflammatory cell infiltration were seen. There was marked increase in the amount of medullary interstitial tissue."

Fig. 4—Microscopic section af an inflamed renal arteriale displaying fibrinoid necrases af the wall with aneurysmal dilatation and thrombosis. Hematoxylin and eosin: mag. X13.

(M.C.B.) 324 East Wisconsin Avenue (2).

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LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service plan.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Occupational Health, A Guide for Medical and Nursing Personnel**—General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
14. **The Income Tax for Wisconsin Physicians**—A brochure, newly revised, containing a review of the state and federal income tax laws as they apply to the physicians of Wisconsin.
15. **The Doctor's Role in Adoptions**—A reprint of three *Wisconsin Medical Journal* articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Knee and Ankle Injuries*

By STEPHEN E. REID, M. D., and MR. THOMAS E. HEALION**
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ATHLETIC INJURIES require different attention than those of the general student body or of the population at large. This specialized attention is not meant to make the athlete a prima donna. An injured athlete cannot be treated in the routine fashion of allowing nature to take its course. Time is essential and many short cuts must be taken to get the player back to his team. The routine care of plenty of rest to the injured part cannot be followed. This type of treatment does not mean detrimental care to the athlete. It requires willingness of the athlete to endure a variable amount of temporary discomfort for the sake of time.

Surgeons generally are becoming increasingly aware of the advantage of early ambulation after major abdominal operations. Patients are encouraged to get out of bed on the day following surgery. Fractured hips in the elderly are nailed and these patients are mobilized immediately with gratifying results. Certainly if these major insults to patients of all ages can be treated without complete rest, an injury to an extremity of a well conditioned football player requires less rest than we have been accustomed to use.

That rest of an injured part can be detrimental is shown by the case of a middle aged man who sprained his ankle in a fall from a ladder. He was instructed to go to bed and rest his injury. When two weeks stay in bed had not healed his injured ankle, he was instructed to continue resting his ankle. After six weeks of rest and out of work, he became desperate and hobbled in on crutches. His ankle was completely stiff, swollen, and indurated. He was unable to bear weight. This man had developed greater disability from disuse than from his original injury.

Since athletes, and particularly football players, are subjected to considerable body contact, their injuries are the result of rather violent force and can often be of a serious nature. We, therefore, x-ray all but obviously minor injuries because of the possibilities of fractured bones. Fractures are thereby discovered early and their treatment instituted.

Our discussion here will cover only soft tissue injuries since they are more common and often more serious. Soft tissues cannot be diagnosed by x-ray examination and therefore may be neglected.

The rapidity with which the athlete can be returned to the game depends on many factors:

1. *The seriousness of the injury:* Obviously, complete tears of the ligaments of the knee, or dislocations at the ankle, will require months, whereas a simple sprain of a joint may cause very little if any disability.

2. *The desire of the athlete to get back to the squad:* A boy may use the injury as an excuse for not being on the first team. He may not have any real desire to play football, but feels he should because of his size; his family, or fraternity brothers, may have encouraged him to go out for the team. This boy may not want to heal his injury. A surgeon cannot put desire into a knee joint. We have been impressed with how few injuries we have after a winning ball game.

3. *The conditioning of the athlete before the injury:* A well conditioned athlete is protected by good muscle tone. We have had many more injuries in the beginning of the season than later. Since the joints are protected by good conditioning, the injury is usually more minor and the recovery period is shorter.

4. *Cooperation of the player, the coach, the trainer, and the physician:* The player must be willing to follow the prescribed treatment for his injury. The

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**Team Physician and Head Trainer, respectively, Northwestern University, Athletic Department.

coach must see to it that the player cooperates with the trainer, and the coach must realize that the physician is anxious to get the athlete cured.

The trainer must be interested in his work, in the team, and in the athlete. The trainer and the team physician must know the shortcomings of each other and must have easy communication. The physician must be interested in the athlete's welfare and yet realize the importance of the boy to his team.

In our experience with the varsity athletic injuries at Northwestern University during the past ten years, ankle injuries have been a lesser problem than knee injuries.

In the absence of a fracture the ankle is wrapped in an elastic bandage. This prevents swelling and allows the ankle to be treated on the following day. Depending on the amount of discomfort, the patient is instructed to bear weight, or use crutches. On the following day after a treatment, the ankle may be strapped and the athlete instructed to walk. He should attempt to walk without limping if possible. It is better to use the ankle normally for a short time rather than limp around for longer periods. The athlete who can walk without a limp is then allowed to jog, and as tolerated, to sprint without cutting. Only when the patient can sprint is he allowed to cut, and finally full activity is encouraged.

Occasionally an obviously severe injury to the ankle is noted without x-ray evidence of fracture. One must be alert to the possibility of a separation of the tibiofibular joint causing a widening of the ankle mortis. This may be demonstrated by x-rays of the ankle in inversion and eversion. In this injury, in addition to the ligaments being torn at the ankle, there may be a tear of the interosseus membrane. This injury should be treated with a cast. After several months calcium may be demonstrated at the site of the tear of the interosseus membrane above the ankle between the tibia and fibula.

Weak ankles can be protected with ankle wraps or adhesive strapping. Since most injuries to the ankle are caused by forcibly inverting the foot, strong leg muscles and tendons splint the ankle and protect this joint. Leg condition, therefore, is vital in the protection of the ankle joint.

Our most common injury and our greatest problem concerns the knee joint. The long bones, the femur above and the tibia below the knee, provide longer effort arms and cause greater strain on the knee joint. This joint cannot be braced adequately to stand such strain without restricting its motion. The football player who wears long aluminum cleats for better footing fixes the foot to the ground. When a blow is applied to the outside of the knee, medial bowing of the leg occurs which may open the joint and possibly rupture the medial collateral ligament. The cruciate ligament and cartilage also may be torn. With these long cleats and with the ankle firmly strapped, there is no "give" and the entire thrust of the blow must be borne by the knee.

We have observed that once a knee is injured, in practically all cases it is subject to re-injury. A good share of our knee problems were the result of previous high school trauma. The disability following a knee injury results in a weakness of the quadriceps muscle group. By favoring his knee the player loses the conditioning he has developed in this large muscle group of the front of the thigh. The power of this muscle which is the greatest protection to the knee, when lost, allows any blow to the knee to be taken by the knee ligaments. The knee then is more easily injured causing more disability and resulting in more quadriceps atrophy. We have seen a two-inch difference in circumferential measurement between the two thighs in a recurrent knee injury.

A case in point is that of a player who injured his knee several times throughout the season. He continued to play football and to maintain the tone in the quadriceps muscle. On examination at the conclusion of the season, this player had a perfectly stable knee joint. He was operated upon for a torn lateral semilunar cartilage which was removed, but, in addition, tears of the anterior cruciate and medial collateral ligaments were found. The stability of this knee was maintained by the well developed quadriceps muscle.

What can be done to protect the knee from injury? The knee joint is supported by four main ligaments.

1. The medial collateral ligament splints the medial side of the knee. Tenderness is elicited over its points of attachment to the femur and tibia when this ligament has been injured. Abduction of the knee stretches an injured ligament and causes pain. A torn or stretched ligament allows the medial side of the

knee joint to open with abduction and demonstrates medial instability of the joint.

2. The lateral collateral ligament splints the lateral side of the knee and produces similar clinical findings with injury to the lateral aspect of the knee.
3. The anterior cruciate ligament crosses the inside of the joint. It attaches to the tibia in front and the femur behind. This structure prevents the tibia from slipping forward on the femur.
4. The posterior cruciate ligament criss crosses with the anterior cruciate ligament, but attaches to the tibia behind and to the femur in front. This structure prevents the tibia from sliding posteriorly on the femur and prevents hyperextension of the knee.

An injury to the cruciate ligaments is demonstrated by forward and backward motion of the tibia on the femur with the knee in 90 degree flexion. This is the so-called positive drawer sign.

The quadriceps muscle in front, and the hamstring muscles in back of the knee add additional support to the knee joint. These muscles can be developed to such a degree that a general anesthetic is required to demonstrate instability of the knee joint due to injury of the ligaments.

Since these muscles support the ligaments of the knee so adequately, conditioning exercises should protect the knee. With weights attached to the foot the athlete, with maximum effort, is required to extend the knee fully. The quadriceps muscle is so developed that the football player is able to lift 90 to 100 pounds successively 10 times. Similarly with weights attached to the foot the athlete flexes the knee against increasing resistance. This exercise strengthens the hamstring muscles.

In the two years, 1951 and 1952, we had 34 knee injuries. Since instituting these exercises two years ago we have had only 8 knee injuries.

Since we feel that immobilizing the ankles with adhesive strapping causes more knee injuries, we strap only the ankles that have been injured and wrap most of the remaining ankles.

The long cleats are also avoided to minimize the chances of knee injuries.

Unstable knees or those with weak ligaments are strapped before all scrimmages.

Summary

We have attempted to show how muscle conditioning splints the knee and ankle joints and protects their ligaments. We have been impressed with the magnitude of some knee injuries and realize that mere casting offers little in the permanent cure of torn ligaments. Early operative intervention is the logical approach in the repair of torn ligaments.

CIRCUIT TEACHING PROGRAMS

OCTOBER AND JANUARY

A series of six teaching programs, consisting of a three-day circuit in October and a second series in January 1960 has been arranged by the SMS Council on Scientific Work in cooperation with the Wisconsin State Board of Health, Wisconsin Academy of General Practice, two medical schools, Wisconsin Heart Association, Wisconsin Anti-Tuberculosis Association, and Wisconsin Division of the American Cancer Society.

FIRST SERIES • OCTOBER		
OCTOBER 13 GREEN BAY St. Vincent's Hospital	OCTOBER 14 ASHLAND Elks Club	OCTOBER 15 WISCONSIN RAPIDS Mead Hotel

SECOND SERIES • JANUARY		
JANUARY 19 VIROQUA Vernon Co. Mem. Hosp.	JANUARY 20 WAUPUN Waupun Memorial Hosp.	JANUARY 21 APPLETON Elks Club

See page 568 for programs of both series

A special feature of the January circuit will be an after-dinner illustrated lecture on "A Physician's Observations in Russia" by Dr. Francis M. Forster, Chairman of the Department of Neurology, University of Wisconsin Medical School, who made a tour of Russia this past year and had the opportunity of visiting a number of medical schools and teachers. Wives of physicians in the areas of the meetings are urged to attend this nonscientific feature of the teaching program.

EACH OF THESE PROGRAMS PROVIDES 4 HOURS OF CATEGORY I CREDIT FOR MEMBERS OF THE WISCONSIN ACADEMY OF GENERAL PRACTICE IN ATTENDANCE

To assist with proper arrangements for the dinner, advance registration is requested. Please use the form below, making your check payable to the State Medical Society of Wisconsin.

RESERVATION FOR CIRCUIT TEACHING PROGRAM: Mail to State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin. FEE (including dinner): $6.00 ($4.00 additional if your wife attends).

I WILL ATTEND THE FOLLOWING CIRCUIT TEACHING PROGRAMS:

		Alone	With Wife For Dinner
Tuesday, Oct. 13, Green Bay: _____	Tuesday, Jan. 19, Viroqua:	_____	_____
Wednesday, Oct. 14, Ashland: _____	Wednesday, Jan. 20, Waupun:	_____	_____
Thursday, Oct. 15, Wisconsin Rapids: _____	Thursday, Jan. 21, Appleton:	_____	_____

NAME: _____ STREET: _____ CITY: _____

A Forced Spray Technique of Surgical Skin Preparation*

By JAMES M. HEAD, M. D., and JOSEPH W. GALE, M. D.
Chicago, Illinois Madison, Wisconsin

SINCE THE INTRODUCTION of the forced spray technique for surgical preparation of the skin prior to operative procedures on the women's general and thoracic surgical services at the University Hospitals, much skepticism has arisen regarding the adequacy of this method. This study has been undertaken to determine the usefulness and efficiency of the technique as compared to other methods employed on the various surgical services. In addition, we will attempt to demonstrate the ease, rapidity, and simplicity with which this technique is employed. At first we felt that this method of preparation would provide deeper penetration of the antiseptic solution into the layers of the skin, thereby affording a better preoperative preparation. We have been unable to demonstrate that this is true. We now know only that the method is as good as the others; its chief advantage is that it is more rapidly and easily applied.

Materials and Methods

In our attempt to find some factual evidence as to the efficiency of the technique, fifty (50) consecutive thoracic surgical patients were studied; the swab technique and the forced spray technique of skin preparation were employed in alternate patients. Skin cultures were obtained from the area prior to application of the antiseptic solution(s) and ten minutes after the solution(s) had been applied and was apparently dry. In the majority of patients a G–11 scrub of the operative area had been undertaken the night before and the morning of surgery.

When the swab technique was used, a solution of green soap and benzine was applied with sponge sticks in a centrifugal pattern, starting at the area of skin incision. This was followed by a solution of 70% alcohol which, in turn, was followed by the tincture of thimerosal (Merthiolate) solution in a similar manner.

The forced spray technique consisted of a 70% alcohol sponge wipe in a centrifugal fashion starting at the area of skin incision. This was followed by the spray solution of tincture of thimerosal using the prep spray gun (fig. 1).

All operative wounds were closed in a similar fashion using running sutures of No. 1 chromic catgut in the muscle layers. The skin and subcutaneous tissue were approximated with 4–5 interrupted vertical mattress sutures of 3–0 plain cotton and a running suture of 3–0 plain cotton.

Postoperatively the wounds were observed for any abnormality in wound healing and

Fig. 1—Prep spray gun used in the forced spray technique.

*From Department of Surgery, University Hospitals, Madison.

for the presence of infection. In the usual patient the wound was inspected at the time of tube removal (usually the third or fourth postoperative day), on the fifth postoperative day when the running skin suture was removed, and on the seventh postoperative day when the interrupted skin sutures were removed. The observation continued daily thereafter until the patient was discharged from the hospital.

All patients in the study were undergoing open thoracotomy for one of the following reasons:

	Patients
1. Pulmonary tuberculosis	33
2. Bronchogenic carcinoma	6
3. Malignant mediastinal tumor	2
4. Fibrosarcoma of the lung	1
5. Bronchial adenoma	1
6. Superior vena caval obstruction	1
7. Diagnostic lung biopsy	1
8. Decortication—chronic empyema	2
9. Echinococcus cyst of the lung	1
10. Traumatic bronchial rupture	1
11. Foreign body in the lung	1
Total	50

All patients received postoperative antibiotic therapy for five to seven days.

Findings

Preoperative skin cultures were positive in all patients. The following eight organisms were cultured and are as follows according to their frequency:

1. Staphylococcus albus	20
2. Staphylococcus aureus	11
3. Diphtheroid	11
4. Gaffkya tetragena	8
5. Paracolon bacillus	2
6. Escherichia coli	1
7. Streptococcus	1
8. Enterococcus	1

These organisms were most frequently cultured in combinations. The organisms most commonly associated with each other were staphylococcus albus and diphtheroid.

All of the skin cultures taken following application of the antiseptic solution (s) were sterile on both smear and culture, except for one patient in whom staphylococcus albus was cultured after employment of the swab technique of preparation. There were no wound complications in this patient.

In the entire group of patients there was not a single wound infection with either of the techniques of skin preparation. In one patient, in whom the spray technique had been used, there were a few small stitch abscesses present in the wound on the fifth postoperative day. These had cleared with routine wound care by the time the patient was discharged from the hospital on the ninth postoperative day. The preoperative skin culture in this patient revealed staphylococcus albus and enterococcus while postpreparation cultures were sterile. The patient underwent a thoracotomy and lobectomy for a peripheral adenocarcinoma of the lung.

Discussion

This method of preoperative skin preparation has been employed since 1950. The impetus for the initiation of this method was aroused as a result of a search for a solution to the problem as to why a cement wall, which is porous, absorbs more moisture during a light, misty rain than after a hard rain. The solution to this problem came from the Bureau of Standards in the statement that rain in a fine mist with a gentle wind would penetrate cement to a greater depth than would a driving rain. With this in mind, then, it was ascertained that an antiseptic solution, if applied to the skin in a fine mist under pressure, would not only penetrate the layers of the skin to a deeper level, but would also be more apt to penetrate into the sweat ducts and down around the hair follicles, the sites where microorganisms are known to be harbored. In an attempt to demonstrate this, skin biopsies were taken from the prepared areas and unstained frozen sections were prepared and observed microscopically. By this means we could demonstrate that only the cornified layer of the epithelium had been stained or penetrated by the thimerosal solution. In no instance, whether the spray or swab technique was employed, could we repeatedly demonstrate deeper penetration into the sweat ducts or hair follicles. We obtained the same amount or degree of penetration with both techniques.

With regard to the convenience of the forced spray technique of skin preparation, one has only to observe the number of solutions used and the mode of application of the solutions in the two techniques to see and agree that the spray technique is more easily, more thoroughly, and more rapidly applied. It is felt that this method is especially simple and convenient in situations where an entire extremity has to be prepared.

We realize that this study does not provide sufficient evidence from which to draw definite conclusions regarding the prevention

of postoperative wound infections. Therefore, we have reviewed the surgical complications with special regard to the number of postoperative wound infections that occurred in a series of 982 cases in which the spray technique was employed and 974 cases in which the swab technique was used. We have found that the incidence of infections in the former series of cases was 1.7% (17 cases), whereas the incidence of infections in the latter group was 3.6% (35 cases). Moreover, the incidence of wound infections on the service where the spray technique has been used has shown no apparent significant increase since our institution of the method. This fact in itself appears to us to be sufficient evidence to permit our recommendation of this technique.

Summary and Conclusions

A forced spray technique of preoperative skin preparation has been described. In our opinion it is apparent from the evidence at hand not only that this method of preparation is completely safe, but also that it is more easily, more thoroughly, and more rapidly applied. It is suggested that this method is especially adapted to situations in which a large field requires preoperative preparation.

(J.W.G,) 1300 University Avenue (6).

Van Meter Prize Award for 1960

The American Goiter Association again offers the Van Meter Prize Award of $300.00 to the essayist submitting the best manuscript of original and unpublished work concerning "Goiter—especially its basic cause". The studies so submitted may relate to any aspect of the thyroid gland in all of its functions in health and disease. The Award will be made at the Fourth International Goiter Conference in London, England, July 5–9, 1960, where a place on the program will be reserved for the winning essayist if he can attend the meeting. For 1960, the recipient of the Award will receive consideration for an award of a travel honorarium.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 1, 1960. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

CIRCUIT TEACHING PROGRAMS

GREEN BAY: Tuesday, Oct. 13
St. Vincent's Hospital

ASHLAND: Wednesday, Oct. 14
Elks Town Club

WISCONSIN RAPIDS: Thursday, Oct. 15
Mead Hotel

Moderator: ROBERT C. PARKIN, M.D. Assistant to the Dean, University of Wisconsin Medical School, Madison

1:30—*Fluid Balance.* DAVID W. SMITH, M.D., Assoc. Prof. of Pediatrics, UW Med. School

2:00—*Plastic Repair of Injury—Primary.* SIDNEY K. WYNN, M.D., Asst. Clin. Prof. of Plastic Surgery, MU School of Med.

2:30—*Gastrointestinal Bleeding.* JOHN LE ROY SIMS, M.D., Prof. of Med., UW Med. School

3:00—*Therapeutic Uses of Blood and Blood Derivatives.* TIBOR J. GREENWALT, M.D., Assoc. Prof. of Med., MU School of Med., and Medical Director, Milwaukee Blood Center.

3:30—Coffee Break

4:00—*Cortisone and Its Analogues—Their Rational Use.* DAVID W. SMITH, M.D.

4:20—*Plastic Repair of Injury—Secondary.* SIDNEY K. WYNN, M.D.

4:40—*The "Nervous" Bowel.* JOHN LE ROY SIMS, M.D.

5:10—*ABO Hemolytic Disease of the Newborn.* TIBOR J. GREENWALT, M.D.

6:15—Dinner

7:30–8:30—Panel Discussion: *Total Care of the Burn Patient in the First 48 Hours.* All afternoon speakers as participants.

The meeting will close at 9:00 p.m. If there is time after the panel, a period of questions and answers will conclude the program.

VIROQUA: Tuesday, Jan. 19
Vernon County Memorial Hospital

WAUPUN: Wednesday, Jan. 20
Waupun Memorial Hospital

APPLETON: Thursday, Jan. 21
Elks Club

Moderator: GEORGE E. COLLENTINE, JR., M.D., Milwaukee

1:30—*Dermatology Clinic.* Review of patients and discussion of cases. DONALD M. RUCH, M.D., Asst. Clin. Prof. of Medicine, MU School of Med.

2:00—*Surgical Management of Intestinal Obstruction.* GEORGE E. COLLENTINE, JR., M.D., Asst. Clin. Prof. of Surgery, MU School of Med.

2:30—*Management of the Convulsive States.* FRANCIS M. FORSTER, M.D., Prof. and Chmn., Dept. of Neurology, UW Med. School.

3:00—Coffee Break

3:30—*Therapy of the Chronic, Draining Ear.* CHARLES R. TABORSKY, M.D., Assoc. Prof. of Surgery (Otology), UW Med. School.

4:00—*What's New in Treatment, and What's Good in What's New.* DONALD M. RUCH, M.D.

4:20—*Recognition and Treatment of Postoperative Complications.* GEORGE E. COLLENTINE, JR., M.D.

4:40—*Treatment of Various Hearing Diseases.* CHARLES R. TABORSKY, M.D.

5:00—Half hour of questions directed to all four speakers.

6:30—Dinner

7:30—*A Physician's Observations in Russia.* FRANCIS M. FORSTER, M.D. (Wives of physicians also invited to the dinner and evening speech).

See page 564 for further details and reservation form

Tubal Pregnancy*

By VICTOR S. FALK, JR., M. D., F. A. C. S.
Edgerton, Wisconsin

PROBABLY THE MOST commonly misdiagnosed disease in the pelvis is ectopic pregnancy. Several series admit errors ranging from 15 to 40%. An ectopic pregnancy is one in which the fertilized ovum is implanted elsewhere than in the endometrium. Since the Fallopian tube is the site of nidation in 95% of ectopic gestations, the term is practically synonymous with tubal pregnancy. This paper will be limited to a discussion of tubal pregnancies. It will present the fallibility of the usual history, the physical findings and the diagnostic aids. The most important factor in making this diagnosis is to develop a high degree of suspicion, an ectopic awareness, alertness or conscience, and to consider it in any female of childbearing age regardless of marital status or menstrual history and regardless of the results of pregnancy tests or uterine curettage.

The ratio of ectopic to normal pregnancy has been tabulated from 1 to 125 up to 1 to 250. Since in Wisconsin in 1957 there were almost 100,000 deliveries, one would anticipate approximately 400 to 800 ectopic pregnancies annually. An estimated 21,000 cases of ectopic pregnancy occur each year in the United States. The age incidence is usually in the range of 23 to 35 years, although one-quarter occur past 35. The condition is found almost equally in all races.

The etiology has been variously attributed to salpingitis, tubal diverticula, peritubal adhesions, congenital malformations, criminal abortions, plastic operations on the tubes, and pressure on the tubes from uterine fibroids or ovarian cysts. Decidual reaction and adenomyosis of the tube may also be factors. Relative infertility and ectopic pregnancy often occur in the same woman; and tubal pregnancy often repeats itself in the same woman, even though the second tube was found to be apparently intact at the first operation.

This tendency to recurrence is definite. In women who become pregnant following an ectopic pregnancy, the chance of a second ectopic pregnancy is ten times greater than in women who have never had one. Because the etiologic-pathologic conditions are frequently present in both tubes, it has been suggested that bilateral salpingectomy be performed to prevent subsequent pregnancy.[1] A second tubal pregnancy may also recur in the same tube or stump following an incomplete salpingectomy. Perhaps there is an increasing incidence of tubal pregnancies due to the use of antibiotics in pelvic inflammatory diseases. Tubal patency is maintained in patients who formerly would have had complete occlusion, but this patency does not insure normal tubal physiology.

In addition to recurrent tubal pregnancy, there are other unusual types. Simultaneous bilateral tubal pregnancies have often been reported[1] as well as a combination of tubal and intrauterine pregnancies. Twin and triplet ectopic pregnancies have been found, and tubal pregnancy has followed subtotal and total hysterectomy. The zygosis of the two gametes is apparently a process determined to progress regardless of surgical efforts to thwart it. Another method of classifying ruptured tubal pregnancies has divided them into acute and chronic. The acute or manifest case is rarely missed as the patient is usually in shock. The chronic case is more obscure as the patient is not in shock, has pain, bleeds a little, walls off the process and the sequence continues until the condition becomes more apparent.

The prognosis depends on the type of ectopic pregnancy and the promptness of treatment. An ectopic pregnancy certainly places a patient in jeopardy and constitutes a true surgical emergency. An untreated acute ruptured ectopic pregnancy is almost universally fatal. Many tubal abortions are probably unrecognized and untreated with no detriment. With blood banks and antibiotics, the operated cases have a decreased mortality rate. Every twelfth maternal death in Chicago and every sixteenth in New York is due to ectopic pregnancy, certainly dis-

* Presented at the Wisconsin Surgical Society Meeting, September 20, 1958, at Land O' Lakes.

proportionate to the ratio of ectopic to normal pregnancies.

The triad of pelvic pain, menstrual disturbance and vaginal bleeding should alert the ectopic-minded surgeon. The pain occurs in almost 100% of cases. The vaginal bleeding is most often a spotting, but may be profuse. There is sometimes a history of amenorrhea, often "two weeks late." Sometimes a history is obtained of previous low abdominal surgery, late marriage, relative infertility, "one child sterility" or previous pelvic inflammatory disease; or the usual symptoms of early pregnancy may be present. Ware[2] declares that 75 to 80% of patients with unruptured ectopic pregnancy do not bear the usual textbook symptoms or signs. At the time of rupture of a tubal pregnancy there is often agonizing pain, faintness, shock and collapse. If the typical picture is not seen, the symptoms may partially subside and the operation be delayed. There will be continued pelvic pain, intermittent vaginal bleeding and even a return to normal menses. Repeated bleeding will produce progressive anemia and a pelvic mass. The true nature of the condition may not be recognized until surgery.

The physical findings are also very variable. Abdominal tenderness, usually in a lower quadrant, is found most commonly; adnexal tenderness, about three-fourths of the time; and a pelvic mass, in only about half the cases.[3] In an effort to establish the diagnosis, repeated pelvic examinations not uncommonly rupture a tubal pregnancy. The shock may occur initially with the loss of just a few ounces of blood and with spontaneous recovery. If the bleeding continues, the patient goes into a real or profound shock. The amount of blood lost slowly over several days may be tremendous and progressive anemia is therefore common.

The differential diagnosis includes abortion, ruptured follicular cyst, pelvic inflammatory disease, appendicitis, and twisted ovarian cyst. Diverticulitis, acute salpingitis, endometriosis, and intestinal obstruction must also be considered in the differential diagnosis.

The diagnostic aids are several and controversial. Posterior colpotomy is a distinct aid but not free of danger as hemorrhage, perforation and infection are frequent complications. Culdoscopy is described by some as an ideal method of correctly diagnosing the obscure case preoperatively and is mentioned only to condemn it as meddlesome curiosity by others. Colpocentesis with a spinal needle is a harmless procedure without complication which can even be done as an office examination with a high degree of diagnostic accuracy.

Biological tests are helpful when positive, although positive results are also obtained in the menopause and with corpus luteum cysts. Diagnostic curettage will show decidual reaction without chorionic villi in one-fourth of ectopic cases, but the absence of decidual reaction does not rule out ectopic pregnancy. If the patient has bled any length of time, the decidua has already shed.

Treatment is laparotomy as soon as the diagnosis is established. Expectant treatment is hazardous, and it is better to operate and be wrong in the diagnosis than to lose a patient by not operating. Although everyone seems to agree on the initial celiotomy, there the agreement ends. Whether to remove all of the free and clotted blood or to leave the blood for autotransfusion has been debated. Since the blood left in the peritoneal cavity is only slowly absorbed and increases postoperative morbidity, I believe it should be thoroughly cleaned out. It is certainly possible that the old blood may initiate peritoneal adhesions, a finding when a chronic ruptured tubal pregnancy is operated. Others think that free blood will not cause adhesions. If blood replacement is necessary, it can be given much more promptly in transfusion form. The extent of surgery on the tube itself is also controversial. The most conservative method is to enucleate the conceptus from the oviduct and not repair the tube. Usually total excision of the affected tube is recommended. More radical is the belief that a total bilateral salpingectomy be performed to prevent recurrence.

Case Reports

Several illustrative cases will be briefly presented.

Case one was that of an unmarried, extremely obese girl of 18 who had never missed a menstrual period. She was first seen because of profuse bright vaginal bleeding of two weeks' duration. The week previous she had had right lower quadrant pain and vomiting for one day. The bleeding stopped completely after oral ergonovine maleate (Ergotrate). At the second visit she

had moderate tenderness over McBurney's point, a leukocytosis of 11,000, and a mild pyuria. When seen for the third time, she had no bleeding, no pain or tenderness, negative urinalysis, and she began a reducing diet. One week later she had an acute rupture of the right tubal pregnancy. The frog test was positive and her hemoglobin 60% immediately before surgery. At operation the tubal pregnancy and appendix were found to be closely entwined, necessitating appendectomy as well as salpingectomy. This case illustrates the unreliability of marital status, menstrual history, or age incidence and raises the differential diagnosis of appendicitis.

Case two was that of a 25-year-old who had had one normal pregnancy and two miscarriages. The more recent miscarriage was followed by two normal menstrual periods. The next month she began very heavy, bright uterine bleeding which continued until a curettage was performed after two weeks at another hospital. A small amount of tissue was obtained and diagnosed by the pathologist as secretory phase of the endometrium. Despite complaints of right lower quadrant pain she was discharged from that hospital. She consulted another physician, and was sent to the Edgerton Hospital with an admitting diagnosis of appendicitis. She complained of pain in the right lower quadrant and right flank. She had a scant bloody vaginal discharge and low grade fever. A catheterized urine specimen had packed fields of pus cells; the white blood cell count was 14,700 with a shift to the left and the hemoglobin was 75%. A subsequent white blood cell count was 17,400 and there was a greater shift to the left. A pregnancy test was requested and reported positive the following day several hours after the operation. About 12 hours after admission the right tubal pregnancy ruptured through a 2.5 cm. defect; the patient became shocky and there was evidence of sudden tremendous blood loss. The patient was given a transfusion of 1 l. of whole blood and withstood the laparotomy and right salpingectomy well. The case illustrates the misleading effects of the diagnostic curettage, the pyuria, and the consideration of acute appendicitis.

Case three was that of a 25-year-old who had had one normal pregnancy five years before. She came in because of right upper quadrant and chest pain. She had had a heavy menstrual flow three days before and also two weeks prior to that. There was tenderness in the right upper quadrant, and on pelvic examination there was extreme tenderness in both adnexae, with fullness on the left and in the cul-de-sac. Although the right upper quadrant pain and tenderness were mildly misleading, the differential rested between an ectopic pregnancy and an ovarian cyst. At operation both were found—a ruptured tubal pregnancy on the right and a hemorrhagic corpus luteum arising from the left ovary.

Case four was that of a 26-year-old weighing 226 pounds who had had one normal pregnancy two years previously and a miscarriage necessitating curettage six months before. She came to the hospital because of severe right upper quadrant pain. She had had normal menstrual periods the two previous months and intermittent bleeding prior to admission. While in the hospital she had a negative cholecystogram, negative intravenous pyelogram which was made because of hematuria, and a negative frog pregnancy test. A diagnostic curettage was performed because of menorrhagia and the pathologist reported proliferative phase of the endometrium with no evidence of recent pregnancy. With the patient anesthetized, a right tubo-ovarian mass could be palpated. During the time that the x-ray and laboratory studies were being carried out, the patient's hemoglobin and hematocrit both improved slightly. At subsequent laparotomy the patient was found to have a ruptured right tubal pregnancy with the tube adherent to a right ovarian cyst, acute catarrhal appendicitis, and diverticulitis of the sigmoid. The tube, ovary, appendix, and two long diverticula from the sigmoid were all in one adherent mass in the cul-de-sac. Six months later this patient again became pregnant, was hospitalized because of prolonged old dark bleeding, subsequently went to term and delivered a baby with a large meningocele.

Case five was that of a 21-year-old who had had one normal pregnancy and a left ruptured tubal pregnancy seven months prior to this admission. There was a history of normal menstrual periods followed by spotting. On examination there was tenderness in the right adnexa, but no mass. A frog test for pregnancy was negative. Subsequently she flowed heavily for 17 days. A dilatation

and curettage was performed. The uterus was small, and only a small amount of endometrial tissue was obtained. However, the uterus was perforated and a laparotomy performed at once. The patient was found to have an unruptured pregnancy in the right tube. A salpingectomy was done, and the pathologic diagnosis in addition to the ectopic pregnancy was chronic salpingitis and proliferative phase of the endometrium. This illustrates the tendency to recurrence as well as the lack of reliance that could be placed on the pregnancy test and diagnostic curettage.

An example of an inaccurate history was that given by a patient who insisted that both tubes had been previously removed. At surgery she was found to have one tube in which a ruptured pregnancy had occurred.

In another case, the pathologist reported both proliferative and secretory phases of the endometrium occurring simultaneously without evidence of pregnancy. The patient had an old ruptured tubal pregnancy.

Summary

A discussion of tubal pregnancies and several illustrative cases have been presented. The variability and unreliability of the history, physical findings, and diagnostic aids were emphasized. It is most important to develop an ectopic conscience and to consider the condition as a possibility in all women during their childbearing years.

The Edgerton Clinic

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1. Findley, D.: Gynecology and obstetrics, Vol. I, Chap. 11 (Ectopic Pregnancy), Hagerstown, W. F. Prior Co., 1953.
2. Ware, H. H. Jr.: Diagnosis and treatment of ectopic pregnancy, West Virginia M. J. 44:49–52 (Mar.) 1948.
3. Farell, D. M. and Scheffey, L. C.: Ectopic pregnancy; review of 75 consecutive cases as compared with previous review of 82 cases, Am. J. Obst. & Gynec. 46:686–695 (Nov.) 1943.

New Booklet on Rheumatic Fever

A new booklet, "Home Care of the Child with Rheumatic Fever," has been published by the American Heart Association and its affiliates.

The booklet was prepared especially for parents of children who have or are recovering from rheumatic fever and for whom hospital care is either not advised or not available.

Copies may be requested by physicians and others to give to parents of rheumatic fever patients, from the Wisconsin Heart Association, 205 West Highland Ave., Milwaukee 3.

The 24-page illustrated booklet goes into detail about the role of the mother in caring for the sick child and the importance of following the regimen prescribed by the physician.

Instruction is included on bathing the child in bed, giving medicine, taking the pulse and temperature and keeping records for the doctor. Choosing and preparing food for the sick child, planning a daily schedule for mother and child and the use of home care equipment are also discussed.

SPECIAL TO THE JOURNAL

Presented under the direction of the Wisconsin Society of Anesthesiologists

Faulty Carbon Dioxide Absorption During General Anesthesia

By K. C. LEENHOUTS, M. D.,* J. J. TISONE, M. D.,* and S. W. GORENS, M. D.**

Milwaukee, Wisconsin

ALTHOUGH THE ADVERSE effects of respiratory acidosis and its rapid reversal in anesthetized patients have long been known,[1, 2] it has only been relatively recently that the high incidence of this complication during general anesthesia has been reported and the etiologic factors re-evaluated.[3, 4] Among these, the part contributed by faulty carbon dioxide absorption is reviewed and a case which we believe is an example of hypercarbia occurring during a general anesthetic, which showed a rather typical clinical course, is presented. The various techniques which were used prior to changing the canister were without avail in reducing the blood pressure. However, when a canister with fresh absorbent was inserted into the system, the clinical signs of hypercarbia disappeared. Unfortunately the patient was not monitored with a carbon dioxide analyzer, but it is felt that in view of the clinical signs it does represent a case of hypercarbia secondary to canister failure which was relieved by the insertion of a large volume canister with fresh soda lime into the system.

Case Report

The patient was a 30-year-old white male who entered the hospital on January 1, 1959, with hematemesis and melena prior to admission. There was a seven-year history of a duodenal ulcer with two previous episodes of massive gastrointestinal bleeding. Other past history was noncontributory.

Pertinent findings on entry were a blood pressure of 112/84 and pulse of 126/min. The chest was clear to percussion and auscultation. The heart had a sinus tachycardia, no enlargements or murmurs.

Laboratory Data: Hemoglobin 9.6 gm., hematocrit 27 mm./hr. The stool was black and positive for blood. On chest x-ray the heart and lungs were normal. Upper gastrointestinal series showed an ulcer deformity of the duodenum. Esophagoscopy was negative.

Course in Hospital: Five units of blood were administered following entry. There was no further evidence of bleeding. In view of the fact that there were three episodes of massive gastrointestinal bleeding, a partial gastrectomy was felt indicated. On February 17, 1959, surgery was performed following induction of general anesthesia. Preoperative medications were secobarbital (Seconal, 100 mg.) and hyoscine (Scopolamine, 0.4 mg.). After receiving thiopental sodium (Pentothal sodium, 100 mg.) and 50 mg. of succinylcholine, the patient was intubated. Ether was then administered in a closed system using a Heidbrink cabinet model with a 9B CO_2 absorber in the system. Respirations were assisted throughout. At the start of surgery blood pressure was 124/80, pulse 60/min. and hemoglobin 13.4 gm. After 90

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minutes the blood pressure and pulse began to rise, and in spite of hyperventilation, continued to rise until the blood pressure was 170/94 and pulse 120/min. After carefully checking each possible etiologic factor, it was decided to place a fresh CO_2 absorber within the system, following which over a period of several minutes the blood pressure and pulse fell from 170/94 and 120/min. to 110/70 and 96/min., respectively, and remained at these levels for the remainder of the procedure.

Hypercarbia

Etiology: Nearly everything concerned with anesthesia and surgery has been justifiably implicated, but basically the patient can either produce more carbon dioxide, or fail to eliminate it, or the anesthesiologist can administer it either intentionally or unintentionally because of inadequate absorption. It is the last factor that is the subject of this article.

Effects: The action of increased carbon dioxide has been well summarized by Waters[1] in the statement which may be paraphrased, that it first stimulates then depresses vital functions. This condition effects primarily those vital functions most necessary for the immediate survival of the patient; that is, the respiratory, nervous, and cardiovascular systems.

The respiratory effects are easily demonstrated by breath-holding during which the extreme urge to breath is due to the stimulating effect of carbon dioxide on the respiratory center. Brown[5] in 1930 working with conscious patients found that a 10% alveolar carbon dioxide concentration caused a 279% rise in minute volume, and more important that after this level was reached there was a rapid depression of respiration.

The central nervous system has long been known to be adversely effected by high concentrations of carbon dioxide. Its narcotizing action has formerly caused it to be used as an anesthetic agent.

The cardiovascular and electrolyte changes are summarized in figure 1. The clinical effects of cardiovascular stimulation during CO_2 retention are well known and consist of an increase in blood pressure with a rise in pulse rate. As carbon dioxide accumulation reaches catastrophic levels the blood pressure and pulse rate fall. During the rapid elimination of carbon dioxide, when the patient is returned to breathing room air, a rapid fall

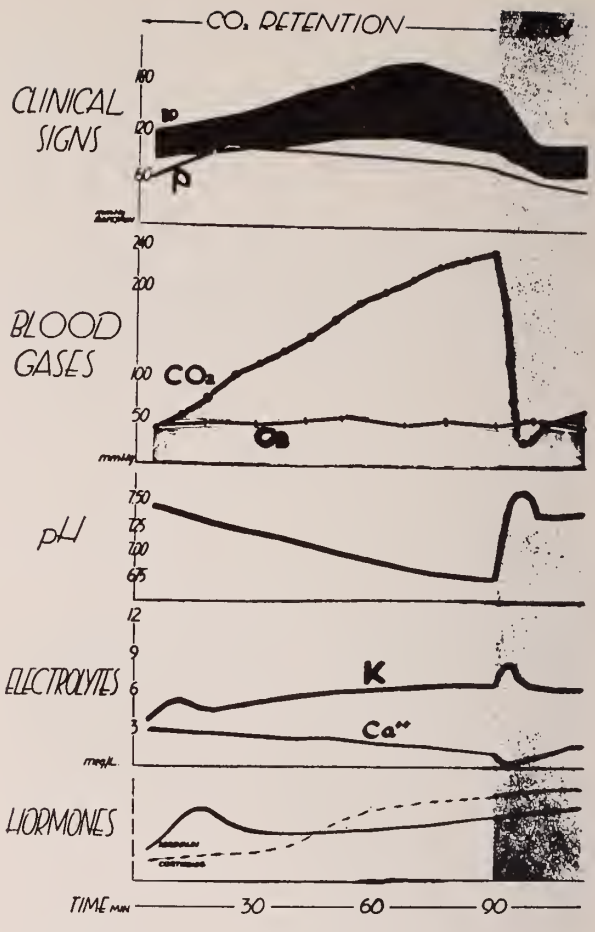

Fig. 1—Effects of acute respiratory acidosis and its rapid reversal.

in blood pressure may occur followed by cardiac arrest. These changes have been attributed to two different mechanisms; one involves the effect of carbon dioxide on the vasomotor center via the carotid bodies, stimulation of which produces a rise in blood pressure.[6] The fall in blood pressure during hypercarbia has been attributed to the direct depressant effect of increased carbon dioxide on the arterioles themselves. During the period of rapid elimination, the sudden drop in blood pressure has been assumed to be a rapid release of the intense vasoconstriction caused by stimulation of the carotid bodies by the previously high CO_2 level. The other mechanism which has been implicated has been that of acute electrolyte shifts which are secondary to rapid changes in pH,[7, 8] and may represent changes secondary to alterations in blood hormone levels which occur during the alarm reaction which has been shown to be triggered by carbon dioxide levels of 10 to 20% in dogs by Richards and

Stern.[9] The pH falls rapidly during accumulation of carbon dioxide; in fact, breath-holding for one minute reduces the pH (which is normally approximately 7.35) to 7.3. This last figure gains importance when it is realized that when CO_2 depresses the pH to 7.2, good anesthesia is obtained and prolonged anesthesia is produced at 7.1, with death usually occurring when the pH drops to 6.9. These two mechanisms, the pH and hormone changes associated with the alarm reaction, cause electrolyte shifts, especially of potassium and calcium.

It has recently been pointed out by Fenn that on a physiochemical basis a decrease in pH should cause a shift of potassium from the extracellular fluid to the intracellular fluid and, therefore, a decrease in the serum potassium. However, as the hypercarbia increases the alarm reaction may be initiated, causing first a release of epinephrine (Adrenalin) from the adrenal medulla.[11] This causes glycogen to break down in the liver liberating glucose and the potassium that binds the glucose molecules together. Secondly, in the alarm reaction anterior pituitary stimulation produces ACTH which causes adrenal cortical stimulation and a release of corticoids, the cellular effect of which is to cause movement of potassium from the cell to the extracellular fluid. These changes associated with the alarm reaction may be the partial cause of an increase serum potassium during hypercarbia.

During the period of CO_2 elimination, the hyperpotassemia increases, but apparently other electrolytes are involved as the potassium level has not been high enough to produce a marked fall in blood pressure and cardiac arrest by itself.[12] Ultrafilterable calcium (which is antagonistic to the depressant action that potassium has on the myocardium) drops during the period of rapid CO_2 elimination.[13] It has also been demonstrated that the heart is more responsive to vagal stimulation during hypercarbia.[14] These three factors, increased potassium, decreased calcium and vagal stimulation, all tend to stop the heart in diastole. The bulk of this work has been done in animals and has not been reduplicated in humans and so it remains speculative. What is known is that during CO_2 accumulation and elimination, violent cardiovascular events may take place, which may be due to potassium accumulation along with other electrolyte and possibly reflex and altered physiologic mechanisms.

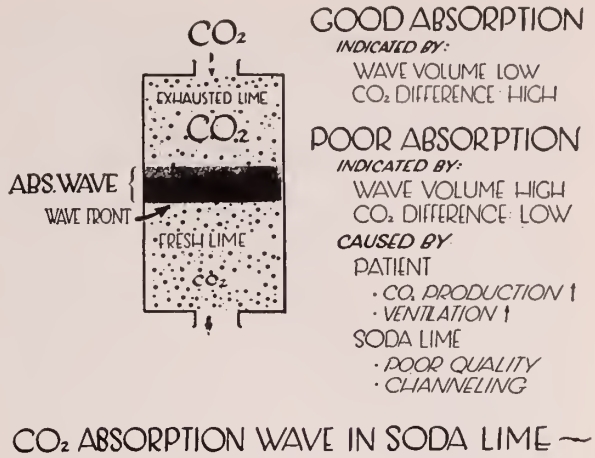

Fig. 2—The characteristics of the absorption wave in a circle canister.

Prevention of Carbon Dioxide Accumulation by Adequate Carbon Dioxide Absorption

There are many factors involved in the prevention of carbon dioxide accumulation other than those concerned with the absorbent and the canister, such as mechanical defects in the anesthetic apparatus and inadequate ventilation of the patient, which have been described many times. It was pointed out in 1955 by Elam and Brown[15] that the high arterial carbon dioxide levels found in anesthetized patients may possibly be due to faulty carbon dioxide absorption using the circle canisters which were then available. Adriani[16] and Brown[17, 18] have suggested several terms and concepts which simplify this problem.[19, 20]

1. *Void Space (intergranular space):* This is the space within the canister surrounding the soda lime granules. The effective void space should accommodate the tidal volume as long as the canister is in use. Only the void space surrounding active soda lime is effective.

2. *Pore Space (intragranular space):* This space is the volume of the minute channels within the soda lime granules. It does not accommodate the tidal volume because of the small diameter of these channels, but carbon dioxide diffuses slowly through these pathways to reach the active portion of the soda lime as the exterior of the granule becomes exhausted.

3. *Absorption Wave:* The orderly progression of the zone of most active absorption along the length of the soda lime bed within the canister is called the absorption wave. By referring to figure 2, it can be seen that car-

bon dioxide entering the top of the canister is first absorbed by the soda lime with which it comes in contact. This forms a wave front which proceeds down through the canister as the soda lime becomes exhausted; thus an active absorption zone is formed with a small amount of carbon dioxide in the void space in front of it and a large amount of carbon dioxide in the void space behind it. This absorption wave gradually transverses the length of the bed and the soda lime is exhausted when the wave front reaches the outlet and carbon dioxide leaves the canister in high concentrations and can be re-inspired by the patient.

Good absorption is indicated by an absorption wave by a low volume and a high carbon dioxide difference between the void space in front of it and behind it. Poor absorption is indicated by the opposite of these two conditions and is caused by increased carbon dioxide production by the patient, or greatly increased ventilation by the patient, which would tend to drive tidal volume through the soda lime before the carbon dioxide was absorbed. The soda lime may also be responsible for poor absorption if it is of poor quality or if there is channeling within the canister in such a way that carbon dioxide cannot come in contact with all the available absorbent.

4. *Absorption Efficiency of the Absorbent:* This is the ability of soda lime to remove carbon dioxide. It is usually expressed as liters per 100 gm. of absorbent.

5. *Time Efficiency of the Canister:* This is the time required for the soda lime to become exhausted to the point where gas leaving the canister to be re-inspired by the patient contains excess carbon dioxide. This end point of efficient absorption is usually given as .5%, since this amount produces no increase in respiratory function, whereas a 1% concentration will double the minute volume.

The problem then becomes a matter of increasing the time efficiency of the canister and thereby reducing the amount of carbon dioxide which is re-inspired by the patient. The time efficiency of the canister is related to the absorption efficiency of the absorbent (which for the purposes of discussion will be considered as soda lime). This contains approximately 95% calcium hydroxide and 5% sodium hydroxide (dry weight), both of which will neutralize carbonic acid after it has been produced following the absorption of carbon dioxide by the water in the absorbent. It is obvious that the bulk of the absorption is accomplished by the calcium hydroxide present. The availability of this calcium hydroxide depends upon the surface areas of the soda lime where carbon dioxide can come in contact with the thin film of water covering the granule. The surface area is in turn proportional to the amount of pore space that is present. The porosity depends upon how the soda lime has been manufactured and how much water it contains. It has been found experimentally that approximately 15% moisture in soda lime will provide adequate solvent in which carbon dioxide can be absorbed without severely occluding the pore space.[18-21] It is known that on the average about 15 liters of carbon dioxide are produced per hour by the average patient and it has been found by Brown and Elam that 100 gm. of soda lime will absorb approximately 15 liters, or one hour's production of carbon dioxide.

	ABSORP. CAPACITY LITERS/100 GM		EFFICIENCY %	ABSORP. WAVE CC.
	THEORY	ACTUAL		
SODA LIME MALLINCKRODT	25.6	20.6	80	200
SODA-SORB	24.0	21.3	89	150
BARALYME PELLETS	25.6	9.8	38	260
GRANULES	24.3	18.1	74	90

Fig. 3—Absorption characteristics of commercially available absorbents.

Figure 3 gives the absorption capacities of some of the commercially available absorbents. Theoretically they should all absorb about the same amount. Only one has an actual absorption efficiency which falls far below its theoretical efficiency and this is probably due to its low surface area.

The time efficiency of a canister can be increased by diverting carbon dioxide away from it (as in a semi-closed system with a high flow of gas).

Time efficiency may also be improved by allowing used soda lime to regenerate. This is accomplished when the sodium hydroxide (which is only 5% by weight of dry soda lime) reforms through a reaction which decreases the amount of calcium hydroxide available for further absorption. The net result is an increase in initial activity after resting, but a gain of only a small amount in total time efficiency.

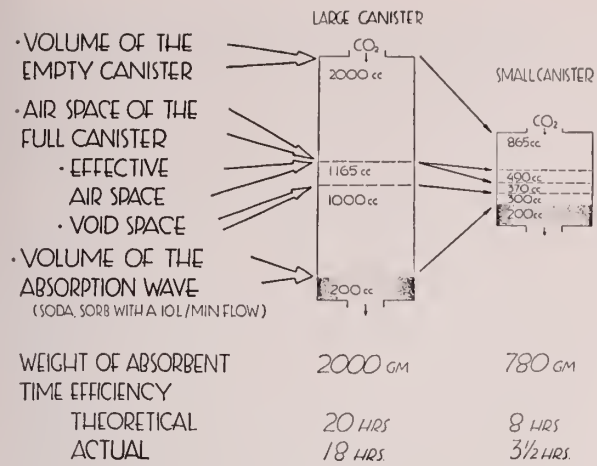

Fig. 4—Comparison of the volumes and time efficiencies of small and large circle canisters.

It would also be possible to increase the amount of carbon dioxide absorbed and, thus, the time efficiency if the mass of the soda lime is increased. This was first suggested in 1955 by Brown and Elam.[15] There are several ways of accomplishing this: either the canister can be changed or it can be enlarged, or both of these things can be done. This is the principal of the so-called double reversible canister, in which the top half is used until it is exhausted; then removed and refilled and placed in the bottom position. The bottom half is then placed at the top. These canisters, which contain approximately 2000 gm. of soda lime, have been found to give an effective time efficiency of approximately 18 hours in a closed-circle system. The reason for their apparent improvement is illustrated in figure 4. The total volume of the empty small canister used in the system on the patient described is 865 cc. The comparable volume of the large canisters averages about 2000 cc. The air space of the full canister includes the void space and the pore space of the soda lime, values for which are approximately 490 cc. for the small canister and 1165 cc. for the large. If there is no channeling in the canister, then the effective air space will equal the air space of a full canister. If there is channeling present, then the effective air space will be smaller than the air space of the full canister and part of the soda lime will not be fully utilized, because carbon dioxide cannot reach it. The void space of these two types of canisters is 300 cc. (when the loss due to channeling is considered) and 1000 cc., respectively. As this is the space which must accommodate the tidal volume, it can be seen that a small increase in tidal volume while using the small canister may result in a high concentration of carbon dioxide leaving the exit of the canister and being re-inspired by the patient. Fortunately, the initial high activity of good quality soda lime often prevents this.

In the large canister an increase in tidal volume will be accommodated by the greater void space available in the canister and the expired gas will not as readily leave the canister without first having its carbon dioxide absorbed. If the volume of the absorption wave is superimposed on the void space, it can also be seen that in the smaller canister all of the soda lime may be active at one time in order to produce effective absorption, whereas in the large canister the absorption wave can form at the top and gradually move down the canister during the course of the anesthetic. By considering the weight of soda lime which each of these canisters contain, it is possible to estimate the time efficiency, as each 100 gm. of soda lime will absorb approximately one hour's production of CO_2 by the average patient. The small canister contains approximately 780 gm. and has a theoretical time efficiency of 8 hours. Actually it has a time efficiency of about 3½ hours to 4 hours, due to the channeling described previously. The large canister, on the other hand, with its 2000-gm. load of soda lime should have a theoretical time efficiency of approximately 20 hours on a closed system. Its actual time efficiency comes very close to this being approximately 18 hours. It is felt that the large canister provides a wider margin of safety against hypercarbia because of the great absorbing ability of its soda lime and also because of its large void space which can accommodate increased tidal volumes which cannot be accommodated in smaller canisters.

Summary

A case exhibiting clinical evidence of hypercarbia during general anesthesia, which cleared when a fresh canister was inserted in the circle system, is presented. The etiology of this condition is discussed from the standpoint of inadequate carbon dioxide absorption, and the effects and possible pathophysiologic mechanisms are described.

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Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

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COMMENTS ON TREATMENT

Griseofulvin, a New Drug for the Oral Treatment of Superficial Fungus Diseases

By STURE JOHNSON, M.D.*
Madison, Wisconsin

EXCEPT FOR THE occasional sporadic use of medicaments by mouth (thallium acetate for epilation in tinea capitis, iodides for *T. rubrum* and gentian violet for *Candida albicans*) the therapy of the superficial fungus diseases of the scalp, nails, beard and skin has been limited to the use of ointments, lotions, powders and soaks. Within the last several months our attention has been called to griseofulvin, a metabolic product of three species of Penicillium, *P. patulum*, *P. griseofulvin*, and *P. janczewskii* in the treatment of superficial fungus diseases of man. This medicament is given orally in doses of approximately 1.0 gm. a day (we have used 2.0 gm. a day) and seems to have definite fungiastatic action on some of the superficial fungi pathogenic to man, but not all. For this reason and due to the present high cost of the drug it will behoove all physicians wishing to employ griseofulvin to make cultures on Sabouraud's media to see if the patient actually has a fungus disease and if so what fungus is at fault. Since griseofulvin has fungiastatic action, it immobilizes and controls some viable fungi (see below) until they are cast off in the keratin of skin, hair and nails which is then replaced by new healthy keratin containing tissues free of fungus; it helps to do manual epilation for tinea capitis and to cut or surgically avulse diseased nails. Diseases due to the following fungi seem to be amenable to the oral therapy: *M. canis*, *M. audouini*, *T. mentagrophytes*, *M. gypseum*, *T. rubrum*, *T. schoenleini*, *T. violaceum*, *E. floccosum*; *T. verrucosum*, *T. tonsurans*, while these due to *Candida albicans*, *M. furfur* and *B. dermatitidis* are not. On the average it takes four to six weeks for clearing to appear but this is variable, there being good results seen in fungus diseases of the scalp, body and feet in two to three weeks and of the finger and toe nails in three to four months. Improvement is noted in disappearance of the scaling and vesiculation, re-growth of nails, loss of itching and return of sweating to the palms and soles. The initial worry about side effects such as decrease in the count and mobility of sperm which were observed when the medicament was given parenterally and not orally to experimental animals, has not been supported by extensive clinical observations and pertinent laboratory studies in many male patients in several clinics. A rebound effect seems to be the rule in that as the drug is withdrawn the count rises appreciably and some of our patients have actually noted an increase in their libido and potentia. It is suggested that complete blood counts be performed at two-week intervals during therapy.

Some patients have complained of feeling light-headed and others have had heartburn, nausea, epigastric distress and diarrhea, all of which has been mild and which has stopped on decreasing the dosage. Specific observations to see whether or not patients sensitive to the widely used penicillin obtained from *P. notatum* might show cross sensitivity reactions have been made and none have been seen. Transitory skin reactions and urticaria have been observed.

The length of therapy varies with the site of infection, severity and should depend on results of repeated potassium hydroxide scrapings, cultures and on Sabouraud's media and Wood's light examination where applicable. Presently it is difficult to say what the incidence of relapses, and reinfection will be in patients thought to be cured.

The medicament though it has some effect on bacteria is not meant to replace the well-known and time-challenged penicillin from *P. notatum* nor is the latter to be used for superficial fungus conditions.

*Professor of Medicine (Dermatology), University of Wisconsin Medical School, Madison.

Changing General Hospital Bed Needs

By VINCENT F. OTIS and E. H. JORRIS, M. D.*
Madison, Wisconsin

THE DECADE FROM 1948 to 1958 was a very fruitful one in the establishment of general hospitals in Wisconsin. Many communities, particularly rural ones where the greatest need existed for many years, have established well-equipped, modern hospital facilities. The Hill-Burton federal grants-in-aid provided much of the incentive for this construction beginning in 1948.

Along with the increasing number of hospitals has come increasing utilization and the provision of additional services in established as well as new facilities. Admissions to our nation's hospitals increased by 100% during the 20-year period 1937 to 1957. In 1937 there were about 70 hospital admissions per 1,000 population, including tuberculosis and mental hospitals. By 1957, this had risen to approximately 140 per 1,000. The increase was affected by the growing number of hospitalized births. In fact, in excess of 99% of our 96,000 yearly births now occur in hospitals. The wide coverage by hospital and medical insurance plans has further encouraged hospital use.

With the development of modern hospital facilities, radiologic and pathologic services have also been expanded in rural areas. In major medical centers there is an increasing interest in rehabilitation facilities. Thus, hospitals have been an important factor in raising the level of medical care to a remarkably high standard and will continue to play an important role in the years ahead.

The following table indicates the increased activities which have occurred in Wisconsin in general hospitals, exclusive of tuberculosis and mental hospitals. For the computation of bed needs, the term "general hospital" includes chronic disease beds formerly computed separately. This has been done because of the increasing trend to care for patients in general hospitals without the provision of separate facilities.

As shown in table 1, the number of general hospital beds available in Wisconsin has increased 30% while the population of the state increased about 21% during the decade. Although there are 4,056 more beds, this increase has kept pace only with the growing bed needs and has not substantially reduced the backlog of additional beds needed. This can be explained by the increase in population and the replacement of some obsolete hospital facilities.

Most of the still unmet need is for hospital beds for chronic disease patients. This is conservatively estimated at about one bed per 1,000 population and is included in the bed needs shown in table 1. An even greater need, however, is for nursing home beds for patients no longer in need of hospital care, but who do need continued skilled nursing and medical supervision. Some 30 general hospitals in the state are now providing this type of care through the establishment of separate buildings, wings, or floors for this group of patients.

The immediate future needs of many general hospitals in Wisconsin may be listed as follows, not necessarily in the order of importance: (1) Additions to hospitals with a continued serious shortage of beds, particularly in fast growing urban areas; (2) Replacement of obsolete hospitals or sections of hospitals which constitute a public hazard; (3) The expansion of patient services in larger general hospitals (150 beds or more) to include psychiatric units; (4) More services to the chronically ill and disabled through expanded physical therapy departments and rehabilitation services; (5) The provision of out-patient departments in hospitals of over 50 beds.

TABLE 1—UTILIZATION OF GENERAL HOSPITALS, WISCONSIN—1948 AND 1958

Year	Total Beds Needed	Beds Available	Population	Hospital Admissions
1958	21,971	17,804	3,932,000*	570,901
1948	18,440	13,748	3,246,000	402,070
Increase	3,531	4,056	686,000	168,831
Per cent	19%	30%	21%	42%

*Source: 1950 U. S. Census of Population (U. S. Dept. of Commerce, Bureau of the Census), adjusted to 1958.

* Mr. Otis is director of the Division of Hospital and Related Services, State Board of Health, Madison; Doctor Jorris is the assistant state health officer.

Another Look at Fair Trade

For several years, retail druggists have advocated the passage of "Fair Trade" legislation. In some states, this type of legislation has already been declared unconstitutional, and the retail groups are busily framing new proposals to accomplish price-fixing.

The advantage of these "Fair Trade" laws are apparent mainly to the retailer who hopes to protect a margin of profit of a size that his competition no longer finds necessary or desirable. The laws are designed to eliminate the possibility of shopping for a bargain in certain types of merchandise, and to arbitrarily fix prices of some commodities in popular demand.

The retail druggists who are more fervent in their advocacy of this type of legislation lose sight of the fact that it is no longer possible to control the total market in a large number of competitive drug lines. Furthermore, since it requires no special training or service to seal a tube of tooth paste or a tin of aspirin, there is no reason—from the consumer's point of view—why the price has to be fixed to guarantee a margin of profit.

Where service, training, and knowledge are important—as in the case of prescription pharmaceuticals—the druggist fixes his own price to compensate himself for these intangibles. On the many other over-the-counter items he handles, the retailer should permit the price to be modified by competition.

When the government fixed prices on commodities during and shortly after the war, the procedure was recognized as socialistic interference with private enterprise. Now the retailers are attempting to accomplish the same result to protect their own profits, and you hear not a word of socialism.

Do Wisconsin Doctors Want Compulsory Social Security?

Self employed physicians are among the very few remaining outside the coverage of the existing social security program. First enacted over twenty years ago after the nation had passed through the traumatic experience of the Great Depression, this program was initially limited to a few categories of employed workers. Gradually the coverage was extended to day workers, part-time workers, and almost all self-employed workers including lawyers, bankers, dentists, and other professional groups. Although it is called "Old Age and Survivor's Insurance", it is generally agreed that it cannot be honestly considered an insurance program. Nevertheless, in the past two decades it has worked well to afford a measure of security and retirement income to many classes of citizens.

Consideration of the extension of the social security laws to self-employed physicians has aroused intense feeling on both sides of the question. Those who advocate inclusion point out that there is no reason why self-employed physicians should not enjoy the same privileges offered to almost every other employed or self-employed worker. Social security benefits are intended to complement, not replace, private insurance and retirement plans arranged by the individual. On the other hand, social security may be the only hope for some doctors who are not insurable by private companies or cannot afford adequate private insurance.

Opponents of the bills introduced in Congress, including the American Medical Association, point out that fewer than 4% of the total physicians in the United States are retired. Since doctors of medicine do not usually retire at the age of 65, most of them would not enjoy the benefits of the social security program until age 72, although they would continue to pay social security taxes. They also point out that physicians usually have their own arrangements for insurance and retirement, and the compulsory social security taxes in reality pay for a coverage not required by most physicians.

The AMA has re-emphasized all the original objections to the social security program: that it is basically a tax program and not an insurance program since there is no contract between the individual and the government and because the taxpayer has no vested right in the benefits. They could be abrogated, legally, by any future Congress. The AMA also points out that the tax rate and income base may be—and, indeed, has been—changed by legislative action. The burden of this program, according to the AMA, may become oppressive to future generations of Americans.

Of prime concern to the AMA is the effect acceptance of social security benefits would have on its general position regarding legislation affecting the medical profession. The Association wishes to avoid the charge that it is willing to accept certain benefits from the government for its members while denying the principle of government-provided social benefits in general.

These are some of the issues involved in the extension of the social security program to self-employed physicians. In future numbers of this publication there will be guest editorials by Wisconsin physicians presenting the case for and against compulsory social security to the end that the statewide poll, when taken, will present the collective opinion of an informed membership. Letters to the *Wisconsin Medical Journal* on this subject, for publication in edited form, will be welcome.

The President's Page . . .

Challenge in Prepaid Plans

Trenton, New Jersey, September 10, 1959—"New Jersey Blue Cross was today granted an average 14.9 per cent rise in its group subscriber rate and an average 17.5 per cent in its nongroup rate. Blue Cross had requested a 17 per cent increase in group rates and a 20 per cent increase in nongroup rates. This was the second increase in 18 months. An average of 18.5 per cent increase in both groups was approved in March, 1958. The New Jersey Blue Cross worried that an additional increase would be necessary before the end of 1960. Blue Cross plans in New Jersey cover 2,260,000 people."

New York, September 1, 1959—"In the State of New York a Blue Cross rate increase averaging 26.5 per cent went into effect today."

* * *

The 83 Blue Cross plans throughout the country had a total operating loss of about 40 million dollars in 1958. At the same time 21 of the 72 Blue Shield plans over the country reported operating losses in 1958.

Everywhere the reports seem to be the same. "We are seeing too much utilization for the premium income." While increases in hospital costs are undoubtedly a major factor in these losses, I am certain that tighter controls must be instituted to reduce the possibility of unnecessary or unusually prolonged utilization without sacrificing quality of care for the patient.

On a broad scale, the subscriber, the hospital, the doctor, Blue Cross, Blue Shield and private carriers had better put their collective heads around the conference table and come up with an answer or increased cost of services will price Blue Cross and Blue Shield out of the market. If that happens, other forces will swiftly and surely move into a ready-made vacuum in the prepaid medical, surgical and hospital care field.

A recent sampling of 500 hospital bills sent into Wisconsin Physicians Service for payment showed that nearly 50 per cent of these were for less than $100.00 each. A $50.00 or a $100.00 deductible hospital insurance policy offered to the public through a positive, vigorous sales and public relations program would, I am sure, go a long way toward keeping insurance rates within the financial reach of the largest possible segment of the public. In this writer's humble opinion, Blue Cross and Blue Shield must take the lead in pioneering such a philosophy or we will be there too late with too little.

William B. Weldenhammer, M.D.

Minutes of Council Meeting
Milwaukee, May 3 and 5, 1959

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:07 p.m. on Sunday, May 3, 1959, Hotel Schroeder, Milwaukee.

All voting members of the Council were present except Doctor Lokvam.

Officers and others present were Doctors Hildebrand, president; Weston, treasurer; Stovall and Simenstad, AMA delegates; Heidner, councilor emeritus; Waldkirch and Sorenson, chairmen of reference committees.

Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Toser, Murphy, Gill, and White; Mrs. Anderson, Miss Nelson, and Miss Pyre.

2. Fall Annual Meeting Date

It was reported to the Council as a matter of information that no progress had been made in the effort to change back to a fall meeting. Auditorium facilities remain committed for the latter part of October to the Milwaukee Community Fund, and for the first of November to the Wisconsin Education Association. The importance of continuing efforts to accomplish the change was re-emphasized, however, in light of difficulties again being demonstrated of preparing for an annual meeting during the height of a legislative session.

3. Keogh–Simpson Bill

Legal counsel presented a proposed petition addressed to the U. S. Senators from Wisconsin, seeking support of this legislation which provides for deferred compensation of self-employed professionals.

On motion of Doctors Bell–Blanchard, carried, the Council forwarded the petition to the House of Delegates with the recommendation that it be approved and signed by all members of the House.

4. Commission on State Departments

By separate motion duly made, seconded and carried, the following were elected for one-year terms:

a. General Chairman: Dr. T. W. Tormey, Jr., Madison.

b. Division Chairmen:

Division on Handicapped Children—Dr. J. W. Nellen, Green Bay

Division on Geriatrics (Aging)—Dr. A. M. Hutter, Fond du Lac

Division on Maternal and Child Welfare—Dr. G. S. Kilkenny, Milwaukee

Division on Nervous and Mental Diseases—Dr. E. D. Schwade, Milwaukee

Division on Public Assistance—Dr. H. W. Carey, Lancaster

Division on Rehabilitation—Dr. Ray Piaskoski, Wood

Division on Safe Transportation—Dr. Dayton Hinke, Richland Center

Division on School Health—Dr. L. M. Simonson, Sheboygan

Division on Chest Diseases—Dr. H. A. Anderson, Stevens Point

Division on Visual and Hearing Defects—Dr. Meyer Fox, Milwaukee

The Council discussed the advisability of creating a position of vice chairman of the Commission as a means of one other than the general chairman acquiring background on its scope of activities, interrelationships of divisions and coordination of their work.

On motion of Doctors Ekblad–Bernhart, carried, the position of vice chairman of the Commission on State Departments was created.

5. Appointments to the State Board of Medical Examiners

Under provisions of the Medical Practice Act, the State Medical Society is invited to make nominations to the Governor from whom he may, but is not required to, appoint successors. The terms of four members were to expire on July 1, 1959.

On motion of Doctors Dessloch–Kilkenny, carried, the Council approved transmission to the Governor of the slate of nominees recommended by the Executive Committee, with two additions.

6. Appointment to State Board of Nursing

The State Medical Society is invited to submit a list of five nominees from which a representative may be selected to serve on the State Board of Nursing for a term of four years.

On motion of Doctors Dessloch–Bell, carried, the Council approved the slate recommended by the Executive Committee.

7. North Central District Blood Bank Clearing House

Notice had been received of the expiration on June 30, 1959, of the term of Dr. T. J. Greenwalt, Milwaukee, as the Society's representative on the Board of Directors of this organization. Its Executive Secretary wrote that Doctor Greenwalt "has been of great help to us. His prime interest is in blood banking, and the Milwaukee Blood Center is and has been most active in blood banking and all its facets, including the clearing house. For these reasons, the Board would be pleased, and extremely so, if the State Medical Society reappoints Doctor Greenwalt."

On motion of Doctors Galasinski–Blanchard, carried, Doctor Greenwalt was reappointed as the So-

ciety's representative on the Board of Directors of the North Central District Blood Bank Clearing House.

8. Ethical Statement

At its last regular meeting, the Council had laid over consideration of a statement drafted by the Secretary in reply to informal inquiries as to possible ethical implications of some one physician performing physical examinations required for participation in a summer camp, or a community-sponsored affair such as athletic competition.

After discussing various aspects of the question, and recognizing that practices vary throughout the state, the Council again laid over action on the statement, on motion of Doctors Dessloch–Ekblad, carried.

9. Council Award

At its 1959 annual meeting, the Council had unanimously voted to grant the Council Award to Dr. Harry Beckman of Milwaukee, and took further action concerning the mechanism for the future, at the request of Doctor Bernhart who felt that all nominees should be known and discussed by the entire Council, and confined within it. The Secretary's suggestion was accepted that past actions relating to the Council Award be reviewed at a subsequent meeting. These actions were reported as follows:

In 1944, reaffirmed in 1947, these three qualifications, each to be met, were adopted by the Council: the physician must have (1) distinguished himself in the field of medicine; (2) served the public in some outstanding capacity; and (3) been of service to his own profession through organized medicine. Nominations in writing to the Secretary were to be distributed to the Executive Committee, and with favorable vote forwarded to the entire Council for a secret mail ballot. Unanimous vote required.

In 1953 the Council authorized presentation "in absentia."

Although the above qualifications refer to "physician," the Council has on three occasions (1935, 1953, and 1958) granted the Award to a non-physician.

On March 1, 1959, the Council adopted a motion that the recipient should not be an active member of the Council at the time it is given. An amendment was also adopted to the effect that nominees be discussed by the Council in executive session and a secret ballot taken; unanimous vote requirement to be retained.

In discussing the matter, Doctor Dessloch and others felt that the Council Award should continue to be regarded as the Society's highest honor and one which need not be granted each year.

10. Report of the Executive Committee

The Executive Committee met Sunday morning, May 3, and the following report was presented by President Hildebrand, chairman:

a. Free Choice—Closed Panels

"At the clinical meeting of the American Medical Association in December, 1958, a report by its Commission on Medical Care Plans on the subject of free choice and the closed panel system was received and action was deferred upon it pending reactions of individual state societies.

"It is inherent to quality medical care that individuals have their free choice of physician, uncamouflaged by the anonymity of closed panel mechanisms. The Executive Committee recommends that the Council advise the Wisconsin delegation to the AMA to stand vigorously on this principle."

Recommendation accepted by the Council on motion of Doctors James–Kief, carried.

b. Membership Certificate

"The Executive Committee has given consideration to the membership certificate which has been used without change for a number of years. It believes that a more dignified type of certificate, containing the general purposes of the State Medical Society, should be developed and provided all members beginning in 1960.

"It recommends to the Council that it approve such a project, on the understanding that the format of the certificate will be approved by the Executive Committee."

Recommendation accepted on motion of Doctors Bernhart–Conway, carried.

c. Size of County Medical Societies

"At a time when there is no pending problem before the Council, the Executive Committee recommends that the Council record in its minutes that while a county medical society can only be organized by five or more physicians, if it should drop below that level it continues as a chartered society."

Recommendation accepted on motion of Doctors Bell–Bernhart, carried.

d. VA Contract for Home Town Medical Care

"The Veterans Administration is making substantial withdrawals of the services being performed by state medical societies with intermediary agencies. There is general concern by the AMA and others as to the circumstances of providing the ambulatory case or the emergency case with services at the expense of the Veterans Administration.

"The Executive Committee has reviewed action taken by the Commission on Medical Care Plans of the State Society, and recommends that authority be issued to negotiate the best contract available, feeling that it is important to provide the veteran with free choice of physician and to provide the physician with the best negotiated fee schedule possible.

"It seems to the Executive Committee that these are the principal reasons for having a contractual relationship with the VA and efforts should be made to maintain the contract for these reasons."

Recommendation accepted on motion of Doctors Bernhart–Dessloch, carried.

"The Executive Committee recommends further:

e. "Election of R. G. Arveson, M.D., as an honorary member of the State Medical Society."

Recommendation accepted on motion of Doctors Bernhart–Blanchard, carried.

f. "That the Council spread upon its minutes, with copy to the University of Wisconsin, its appreciation for the public service performed by Professor M. F. Guyer, deceased, not only as a teacher in the basic sciences, but as a member and president of the first Basic Science Board of Wisconsin."

Recommendation accepted on motion of Doctors Blanchard–Hill, carried.

g. "That inquiry be made as to authority of licensing boards in this state, as to their ability to legislate as to the definition and scope of a particular practice."

h. "That three resolutions, whose introduction was requested by the Douglas County Medical Society, be forwarded to the House for its consideration." The text of these resolutions and action upon them will be found in the transactions of the House of Delegates (printed in the August issue).

i. "There are several conferences being held nationally and regionally as a preliminary to the White House Conference on the Care of the Aged. The Executive Committee recommends that Wisconsin participants in behalf of the State Medical Society be requested to urge insurance programs which do not substantially discount physicians' fees, but, on the contrary, consider them as realistic to the income group being served."

Recommendation accepted on motion of Doctors Dessloch–Ekblad, carried.

j. Commission on Hospital Relations and Medical Education

The Executive Committee presented a special report on the matter of overlapping jurisdiction and responsibility of several committees concerned with hospital relations and medical education, with the recommendation that the House of Delegates be asked to consider the establishment of a new Commission on Hospital Relations and Medical Education.

On motion of Doctors Bernhart–Hill, carried, the Council accepted the report and recommendation, which will be found in the House transactions (printed in August issue).

11. Executive Session

Upon conclusion of the executive session, Chairman Fox reported the following for incorporation in these minutes:

The Council met in executive session and discussed at great length the situation regarding Milwaukee County; and finally, a motion was made by Doctor Conway, seconded by Doctor Bernhart, that the Chairman of the Council or the President of the State Society inform the House of Delegates to the effect that the committee appointed by the President of the State Medical Society and a committee appointed by the President of the Milwaukee County society have met, are meeting at the present time, and will continue to meet in the future in order to offer appropriate recommendations regarding the settlement of the problems between Milwaukee County and the State Medical Society as quickly as possible.

Another motion was adopted, by Doctors Conley–Bernhart, that the president's committee of the State Medical Society be instructed to report to the Council of the State Medical Society in executive session. It is recommended that this committee report likewise to the Milwaukee County society board of directors in executive session.

12. Adjournment

The May 3, 1959, meeting of the Council adjourned at 5:15 p.m.

13. May 5, 1959, Session

The Council met again at noon on May 5, and its actions will be found in a supplementary report to the House at its second session (printed in August issue). They relate to the American Medical Education Foundation; medical education at the University of Wisconsin Medical School and the operation of Wisconsin General Hospital; and a resolution to amend the bylaws and provide for an oath of office.

C. H. Crownhart,
Secretary

Approved:
James C. Fox, M.D.
Chairman of the Council

Wisconsin Physicians Helped "Shape Our Destiny"

A recent study by the American Medical Association has revealed that 361 physicians have "helped shape the destiny of the country" as members of Congress.

Three of the physicians were from Wisconsin.

If the study does nothing else, said the AMA, it will point up the fact that there is nothing new, unusual or improper for doctors to take an active part in the nation's government.

One of the first such physicians was Dr. Joseph Barlett. He became governor of New Hampshire, signed the Declaration of Independence and was one of four physician members of the Second Continental Congress in 1775.

Doctor Henney

Earlier congresses had more doctors serving than the more recent ones. A record was reached in 1835 when there were 18. The present Congress has five, one of whom is Dr. Walter H. Judd, a representative of neighboring Minnesota.

Altogether, the survey tallied 165 Democratic physicians in Congress, compared with 68 Republicans. Pennsylvania has contributed the most: 52.

The three physicians from Wisconsin were Dr. Mason Cook Darling, a Democrat who served in the House from June, 1848 to March, 1849; Dr. Alexander Stuart McDill, a Republican member in 1873–74; and Dr. Charles W. Henney, a Democrat who was elected for one term in the Roosevelt landslide of 1932.

Doctor Darling was a native of Amherst, Mass., moved to Wisconsin in 1837 at the age of 36. He was one of the original settlers of Fond du Lac. He became a member of the territorial legislative assembly. Later, he was one of the first Congressmen elected when Wisconsin became a state in 1848.

—Photo Courtesy Underwood & Underwood, Washington, D.C.

SECTION ON MEDICAL HISTORY

Doctor Darling did not stand for re-election to Congress, instead was elected the first mayor of Fond du Lac in 1852. He resumed his practice of medicine, and dealt in real estate on the side until 1864, when he moved to Chicago. There he died in 1866, but his grave is in Rienzi cemetery in Fond du Lac.

Doctor McDill was a native of Meadville, Pa., and moved to Plover (Portage county) in 1856 when he was 34. He was a member of the state Assembly in the Civil War year of 1862, then went into the state Senate for the following two years. He was also a presidential elector on the Republican ticket of Lincoln and Johnson in 1864.

Before going to Congress in 1873, Doctor McDill was medical superintendent of the state hospital for the insane. He was an unsuccessful candidate for a second term in Congress. He died near Madison and is buried in Forest Hill cemetery at Madison.

Dr. Charles W. Henney was born on a farm near Dunlap, Iowa, in 1884, graduated from Northwestern's medical school in 1910, interned at Cook County Hospital, Chicago, for the next two years.

He moved to Portage in 1912 at the age of 28. He began practicing medicine, specializing in surgery. Even before he became a congressman he was highly active in politics. He served as a delegate to all Democratic state conventions from 1920 to 1936.

When he did not win a second term in Congress, Doctor Henney resumed his practice in Portage where he currently resides. In 1936 he was elected as president of the Columbia County Medical Society. For the next nine years he was chief of staff for the Divine Savior Hospital, Portage, and from 1945–54 chief of surgery. His son, Thomas E. Henney, followed him into medicine in Portage.

THE MEDICAL FORUM

STATE AFFAIRS

HOSPITALS

SMS Awards Program

President William B. Hildebrand has sent to all chiefs of staff full particulars on the new SMS "community achievement awards" program for Wisconsin hospitals.

Starting in 1960, an annual series of awards will be presented to small, medium and large hospitals which have demonstrated achievement in improving facilities and service or expansion of their overall usefulness to the community.

All voluntary hospitals, including municipal, state, and county hospitals located in Wisconsin, which offer primarily acute general hospital service to their patients are eligible to participate.

There are three classes of awards: small hospital (under 50 beds), medium (51-150 beds), large (151 and over); bassinets are excluded in the bed count.

The awards program is to be conducted through the chief of staff of each hospital. He nominates his hospital by submitting a 500–750 statement no later than March 1, 1960 to the SMS Executive Committee of the Commission on Hospital Relations and Medical Education, which will judge the winners.

Some of the criteria to be evaluated:

1. Contribution to the community health.
2. Physical expansion.
3. Additions or expansion of patient service.
4. Unusually cooperative relationships between medical staff, administrator and governing board aiming at better patient care.
5. Special or overall situations involving the entire hospital health team.
6. Presenting to the community a Career's Day program in the medical field.
7. A disaster program, postgraduate efforts or special training for nurses and aides, and similar programs.
8. Unusual life saving experience within the hospital such as use of heart stimulants, resuscitation equipment and techniques.
9. Longevity of the hospital's service to the community.
10. Public attitude toward the hospital.

Awards will be in the form of attractive plaques or scrolls and will be presented during National Hospital Week.

Prairie du Chien Courier–Press Photo

ANOTHER STEP FORWARD toward the creation of the Medical Museum of Wisconsin at Prairie du Chien was taken in recent weeks when repairs were made to the Fort Crawford military hospital. Reconditioning included painting all woodwork, repairs to the windows, sanding and sealing the porch floors. The hospital, where Dr. William Beaumont conducted his far-reaching discoveries in the physiology of digestion a century ago, is the first of four buildings in the planned museum. When completely restored, the hospital will once again house Dr. Beaumont's office, a typical military hospital ward of the period, and an examination room containing displays of medical memorabilia. Other structures will illustrate the progress of medicine through the ages. Approximately one third of the needed $350,000 for the entire museum has been raised by the Charitable, Educational and Scientific Foundation through voluntary contributions.

STATE AFFAIRS

POLIO ROUNDUP

Monroe County

The weekly Elroy *Leader–Tribune* reports that Monroe County physicians "feel that no person should be deprived of polio vaccine because of their inability to pay. For this reason they are continuing to give their services free of charge, and Monroe county will continue to provide polio vaccine to persons who are unable to pay."

Racine County

Dr. Albert C. Edwards, city health commissioner, stated that a recent survey revealed that less than one-fourth of the persons in households of the lower socio-economic group have received three or more doses of vaccine.

On the other hand, those in the upper socio-economic echelon appear to be well vaccinated.

Estimates are that about 25% of all persons under 40 have received no vaccine. In the lower income bracket, about 50% of the children under five have no protection.

Racine's public health polio clinic is operating at "full capacity," is open to all between the ages of 3–19.

Rusk County

"Bouquets for Local Doctors" read an editorial from the weekly Ladysmith *News* when it learned that local psysicians were participating in public polio clinics.

"The doctors make no charge for taking the time to administer the shots at the clinics. The 50-cent fee goes to cover costs of the serum and equipment . . . we should be mighty proud of our doctors for this unselfish service," concluded the *News*.

Brown County

The Brown County Chapter of the National Foundation was informed last month that national aid had been cut.

The local chapter, which in the past has supplied financial assistance for care and rehabilitation of polio patients, has exhausted its funds and outstanding bills amount to about $11,000.

The National Foundation said that polio epidemic areas elsewhere have caused curtailment of aids to Brown county.

Milwaukee County

"Are we doing enough to stop polio? Not all places are," commented the Milwaukee *Journal*.

". . . Wouldn't it be well for local medical societies and public health officials to review the local programs?

Is the effort adequate? Are highly susceptible preschool children being vaccinated in proper numbers?

DR. JOHN S. HIRSCHBOECK
Research in Milwaukee . . .

Are lower economic groups being reached? Are the fees charged—usually $1 in public clinics and $3 to $5 privately—too great a hindrance?

"Perhaps what we are doing is enough. If it isn't, however, it would be better to find out now than to have the program tested by an epidemic — and be found wanting."

Marathon County

"Salk vaccine clinic off to fast start," reported the Wausau *Record–Herald* as the first of a series of county-wide public clinics opened in August.

The Marathon County Medical Society, cooperating with the county health unit, opened clinics to all age groups. First week some 1,500 men, women and children showed up for shots.

"Free will offers" were being accepted by those who could or wished to pay part of the cost.

Sheboygan County

Sheboygan last month had its first polio case in two years. The victim, an 8-year-old boy, had never been vaccinated.

At the same time the Sheboygan County Medical Society "re-emphasized" that its policy was vaccine at reduced rates or no charge at all when "patients indicate that payment of the usual charge is a financial hardship."

Dunn County

Dunn County Medical Society, in cooperation with local health and polio officials, has set up polio clinics for children from three months through 18 years. First inoculation is $1.

Clark County

Clark County Medical Society and the county health committee is again sponsoring an immunization program against polio, diphtheria, whooping cough, tetanus and smallpox.

Clinics are open to all pre-school and school-age children. Charge for each immunization shot: 50¢.

EDUCATION

Marquette Medical Center

To co-ordinate medical education and research in the Milwaukee area Marquette University has activated plans for a major medical center.

The aim of the center, said Dr. John S. Hirschboeck, Medical School Dean, would be to bring together hospitals, other medical facilities and the medical school for more efficient, higher quality teaching, research and medical care.

The new center would also avoid unnecessary duplication of research and treatment facilities. For instance, there are three cobalt therapy machines in the community now. One probably would be enough, it is estimated.

From Marquette's standpoint, said Dr. Hirschboeck, the proposed center has no problems "more basic than the financial one."

"It obviously will be necessary" to permit full time faculty members of the Medical School a limited private practice to help their own financial support, stated Dr. Hirschboeck.

CIVIL DEFENSE

Army Courses Offered

Department of the Army has made the following spaces available for civilian physicians interested in Management of Mass Casualties courses during the next nine months:

Walter Reed Army Medical Center, Washington, D. C.; Feb. 15–20, 1960;

Brooke Army Medical Center, San Antonio, Texas; Nov. 30–Dec. 4, 1959; Feb. 15–19, April 25–29, June 13–17, 1960.

Quota for each course is two physicians. Write directly to the Council on National Defense, AMA, 535 N. Dearborn, Chicago 10.

INSURANCE

Wisconsin Farm Bureau

Two new hospital insurance benefits for persons 65 and over have gone into effect for policyholders of the Rural Insurance Companies, and affiliate of the Wisconsin Farm Bureau Federation.

The hospital and surgical policy will now be guaranteed renewable for life if an individual 65 or over has carried continuous hospital and surgical insurance with Rural for 10 years.

The second major change is that full benefits will be payable up to age 70 instead of 65, with full coverage of 90 days on hospital room and board allowance.

The changes are for both group and non-group policies, and may affect 5,000–6,000 people.

DOOR COUNTY

Hospital Questionnaire

Recently the citizen's advisory committee for Door County Memorial Hospital met to discuss results of a questionnaire on future hospital plans.

The questionnaire had been publicly circulated throughout the area, and returns were surprisingly high. About 50 per cent carried added comments.

Results are still to be evaluated but the answer to one question was most significant: the vote was better than eight to one against having outside fund raisers handle any future campaign.

BOARD OF HEALTH

Elections

The State Board of Health last month re-elected Dr. Samuel L. Henke, Eau Claire, as president and Dr. William T. Clark, Janesville, as vice-president for the coming year.

DR. SAMUEL L. HENKE

. . . and re-elections in Madison

The board also appointed two newcomers to the advisory committee on nursing homes and reappointed four members to the advisory hospital council.

The new appointees on the nursing home committee are A. M. Hutter, M. D., Fond du Lac and Warren Von Ehren, administrator of Bellin Memorial hospital, Green Bay. Both will serve three year terms starting October 22.

The reappointed officials on the advisory hospital council are: H. M. Coon, M. D., Milwaukee, H. A. Sincock, M. D., Superior; Mrs. Otto Falk, Oconomowoc, and W. R. Plater, D. D. S., Madison. All will serve three year terms beginning August 1.

In addition, both Dr. Plater and Dr. Sincock were reappointed to positions on the advisory committee on hospital regulation and approval. These appointments, both for three years, also are effective on August 1.

Dr. Henke has served as president of the board since July 1957, while Dr. Clark has held his position since June of this year.

Dr. Coon, who has served on the advisory hospital council since August 1, 1947, represents hospital administration; Dr. Sincock, represents medicine; Mrs. Falk, a consumer of hospital services, and Dr. Plater, dentistry; all have been members of the council since August 1, 1950.

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STATE AFFAIRS

INSURANCE

M. D. Disability Plan

The physician, because of the nature of his profession, has always lived with a major haunting fear: disability, partial or whole, with its attendant and destructive shutoff of income.

Since 1950, however, the SMS, with its collective purchasing strength, has been able to arrange a group disability income insurance plan at very favorable rates for all Wisconsin physicians.

The plan, written to Society specifications and underwritten by Provident Accident Life & Accident Insurance Co., of Chattanooga is now entering its tenth year. There is plenty of evidence that it has payed off in protection.

Said Provident in a recent report: "The plan has been and continues to be a tremendous success

During the last year alone, stated Provident, well over $200,000 were paid in claims, and in excess of $1,800,000 had been returned to Wisconsin physicians in the nine years of operation.

What were the claims like? Provident reported that in the past 12 months a total of 509 claims were paid of which 95 resulted from accidental injuries and 414 from sickness. Among the sickness claims were 165 paid for heart and circulatory disorders, 20 for malignancy, 12 for gastric disorders and 29 for conditions of the back.

The Society has always maintained a measure of control over the group policy that has given added protection to the lone physician. It investigates and reviews any dispute that may occur between the claimant and the insurance company.

"It is a very, very rare occurrence that a disputed claim is brought to the attention of the Group Insurance Committee," noted Provident.

The master policy, tailored to SMS requirements, is as broad as possible: new Society members under 32 may apply for coverage within one year, those over age 32 within six months. In either case there is no consideration of present physical condition or past medical history.

The insurance cannot be cancelled unless the individual physician doesn't pay the low premium, reaches age 75, drops active membership in SMS, ceases to practice medicine. The master policy can be cancelled by SMS or the company, but only on annual renewal date and only with 60 days advance notice.

The strength of the policy is still group purchasing power and both SMS and Provident were happy to calculate 280 new applications during the past year.

For the individual physician the plan should continue to lessen that haunting fear of disability.

West Allis Star Photo

TRAFFIC SAFETY SIGN in West Allis cleverly calls for no accidents because "our hospital's (West Allis Memorial, now abuilding) not open yet!"

YOUTH

4-H at New High

The number of 4-H members in Wisconsin has reached a new high; 51,001.

This is an increase of approximately 2,550 members for each of the three years.

About 12,000 adult leaders guide the program of 2,400 clubs whose slogan is Head, Heart, Health, Hands.

SMS annually underwrites the cost of a 4-H leaders meeting with SMS officials, aimed at guiding club health projects. SMS also annually awards $100 to an outstanding 4-H-er and distributes a number of *Today's Health* subscriptions to clubs which have carried out meritorious health projects.

RHEUMATIC FEVER

Free Guide

A new guide for parents, *Home Care of the Child with Rheumatic Fever*, has been published by the American Heart Association. Physicians may obtain copies of the booklet from local heart chapters.

STATE AFFAIRS

CHIROPRACTIC

Advertising Age

One of the most respected publications in the field of advertising is the authoritative *Advertising Age.*

Its annual "Creativity in Advertising" seminar this summer in Chicago attracted record crowds from around the U. S., and such big names as the J. Walter Thompson Company (largest ad agency of them all) conducted the four-day studies.

Prominent in a "class" photo of the "students" attending was Gene Wiechec of the Michigan State Chiropractic Society. It was obvious that chiropractic, astute as ever, had come of advertising age.

Public Relations

The Medical Forum misplaced a news clipping during the month of April, then found it the other day. Although old, its public relations message is significant:

"Wisconsin chiropractors are inviting fifth and sixth grade students in Wisconsin schools to participate in a good posture poster campaign during Correct Posture Week, May 1–7.

"J. R. Stacker, Port Washington, state chairman for the project, said the campaign is designed to supplement the President's Youth Fitness Program."

NARCOTICS

Stiffer Penalties

Gov. Gaylord Nelson has signed into law far stiffer penalties for violators of the narcotic drug act.

New legislation doubles the old five-year maximum jail sentence to ten years for a person who may "manufacture, possess, have control of, buy, sell, give away, prescribe, administer, dispense or compound any narcotic drug, except as authorized" by law.

Maximum penalty for unlawful use is increased from two to five years. "The unlawful possession of narcotic drugs by a person or of a hypodermic syringe or needle, *except when possessed by a diabetic,* shall be prima facie evidence of the unlawful use of such drugs . . ."

MEDICARE

Modified Maternity Benefits

Effective July 28, 1959, the Armed Forces modified the policy on obstetrical and maternity car for the wife of a serviceman who has died on active duty.

1) If a dependent wife, who is eligible for Medicare, is pregnant at the time of her husband's death, she may obtain authorized obstetrical and maternity care from a civilian physician. This includes postpartum care for the child.
2) There is a new DD Form 1173 to be used by physicians in Medicare cases. It does *not* authorize Medicare from civilian physicians. Nevertheless the widow still has her choice.
3) "When appropriate", the widow will be issued an official letter which does authorize Medicare from a civilian physician. In fact, the official letter alone is sufficient authorization. The new DD Form 1173 need not accompany it. Thus completion of items 6 and 7 of the DA Claim Form 1863 are waived in these cases *provided:*
   A. Copy of the official letter is attached to the Claim Form submitted by the civilian physician and/or the hospital furnishing the care.
   B. The attending civilian physician attaches a statement that, in his opinion, the dependent was pregnant on the date of the husband's death as shown in the official letter.

Example: If a serviceman died on Nov. 15, 1958, and his widow was pregnant on that date (in the attending physician's opinion), and is delivered on Aug. 1, 1959, she and the child will be eligible for the above-described benefits for the entire period of pregnancy as well as the authorized postpartum period.

TETANUS

One More

When President Hildebrand issued his tetanus warning recently, he singled out three cases in the Sheboygan–Manitowoc area as examples. Fortunately, all were reported as recovered.

But not so with Frances June Barlow, an 8-year-old girl of Viola (Vernon county). Frances had had her regular immunization series as an infant. When she fell from a truck in early August, she was given a booster shot as part of treatment for a compound fracture of the right arm.

Five days later lockjaw symptoms appeared and the child was taken to the University Hospitals. Four days later little Frances was dead; the third fatality in 1959.

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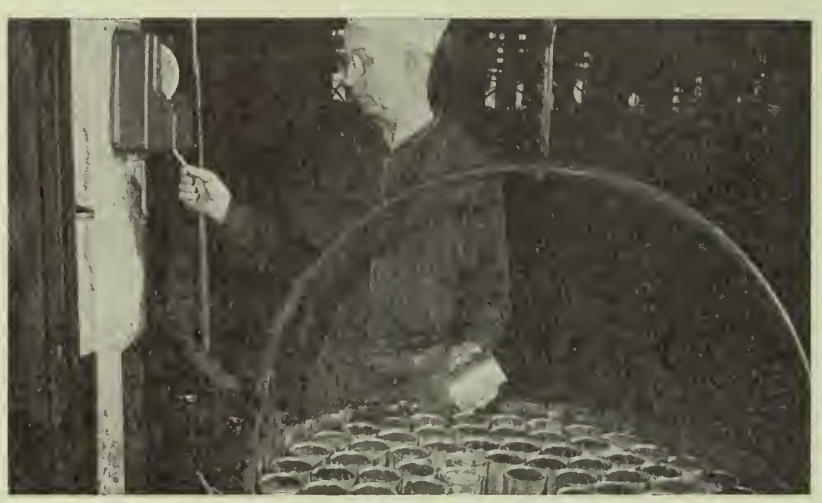
STATE AFFAIRS



A NEW TECHNIQUE in food sterilization is used by Larson Canning Co., Green Bay. A pressure sensitive tape, placed on canned foods, reveals dark colored stripes when sterilization is complete.

PRESS

First Shriek of Siren—Hospital*

When the first shrill shriek of an ambulance siren was heard in New London Sunday morning (Aug. 30 ed.), it marked the most tragic crash scene ever witnessed here.

Those who were first to arrive on the two-car crash scene at the 45–54 intersection turned in horror at the sight of injured children lying on the road or trapped in cars, 13 persons in all. All needing hospital attention. Some too far gone for help.

And with the first shriek of a siren Community hospital became the focal point of the emergency center.

Local doctors hurried to the scene or hospital to handle the injured. Dr. Fred Pfeifer, who was on emergency duty that day, went first to the scene and then the hospital. Dr. H. C. Schmallenberg was at the hospital when the first injured arrived. Dr. G. M. LaCroix, Shiocton, arrived at the hospital with the first ambulance. Dr. J. H. Van Gilder of Hortonville, who was on relief call, was summoned. Dr. George Dernbach, Dr. J. E. Gmeiner of Appleton and Dr. R. H. Quade, Neenah, also rushed here to help. Dr. Gordon Meikejohn of the hospital's dental staff remained at the hospital all day.

The doctors were wonderful, Sister Superior Rideout said. The hospital was turned into a state of emergency. Off-duty nurses, and nurses aides came to help. And as the word of the tragedy became known, the hospital was swamped with calls offering blood or other help. The Grey Ladies and the clergy came to the hospital to offer their help and prayers.

Every available space was put to work. The emergency rooms were full. And regular hospital personnel from the janitorial service to the kitchen workers took on extra duties to handle the crisis. Blood was brought here from neighboring cities—from Waupaca, Appleton and even as far as Stevens Point.

As one sober telephone caller said Monday morning: this disaster should bring closer to the minds of New London people the need for blood at bloodmobile time—for a disaster strikes suddenly.

* An editorial from the New London *Press*.

HEALTH INSURANCE

Ambitious New Merger

A recent merger of two group health associations may have considerable effect on the conduct of medicine in Wisconsin.

Meeting in New York, the Group Health Federation of America and the American Labor Health Association merged and adopted a new name: Group Health Association of America.

The GHAA is aimed largely at the creation of group practice insurance, such as Kaiser and HIP, but adapted to cooperatives. Thus, Wisconsin, with its large number of co-ops, is bound to feel its influence.

GHAA is backing the Forand Bill (H.R. 4700) and S. 2009, a bill introduced by Sen. Hubert Humphrey (D-Minn.). S. 2009 basically is a bill to use tax money to construct and maintain clinics and related facilities for closed panel prepaid plans.

GHAA also has an ambitious seven-point program which all 50 state legislatures will be urged to adopt:

A) a statute legalizing group health plans and overruling the corporate practice of medicine rule and any conflicting provisions of the insurance law;

B) a pathology statute requiring all tissue removed during surgery to be examined by an approved pathologist, and a written report filed with the hospital and with the State Department of Health;

C) a hospital non-discrimination statute prohibiting hospitals, public or private, from limiting medical staff privileges solely because a physician is employed by or associated with a closed panel (Ohio at the present time has a somewhat similar proposal pending before its state legislature);

D) a statute called "the Medical Anti-Trust Law" specifically providing that concerted action against any form of medical prepayment plan is an unlawful conspiracy;

E) a statute adding two lay persons to the State Board of Medical Examiners;

F) a statute adding one or more lay members to the State Board of Health; and

G) finally, a statute creating a study commission to survey and re-

port upon the shortage of physicians and to recommend means of "solving this urgent problem"

Howard Hassard, General Counsel for the national Blue Shield, labels the GHAA legislative program as ". . . the oblique approach toward fostering closed panel practice and crippling both the private practice of medicine and free choice pre-payment methods."

AMA

Arrogant Advertising

The case for federal action in cleaning up medical advertising was made even stronger in recent weeks by the arrogant action of the Vitasafe Corporation, a New York City mail-order vitamin house.

The Vitasafe ad, still appearing in the nation's newspapers and magazines, features a premium give-away offering "The Official A.M.A. Book of Health" plus a 30-day supply of "high-potency capsules."

The "Book of Health" is actually a collection of reprints from the AMA's *Today's Health.* And AMA, in selling reprint rights (to a Wisconsin-owned publishing house), had surrendered control and distribution to the contractor, as is customary.

As Vitasafe plastered the country with ads that implied AMA endorsement of its products, the national medical association took what action it could: protests to the Federal Trade Commission, letters to major metropolitan newspapers and consumer magazines, news releases to pharmaceutical, medical and advertising publications.

Meanwhile Vitasafe continued to advertise and peddle its pills.

MENTAL HYGIENE

Up Wisconsin

A cheering pronouncement on the Wisconsin's emotional health has been delivered by Dr. Leslie Osborne, director of the state Division of Mental Hygiene.

Writing in the foreword to a new publication of the State Department of Public Welfare, Dr. Osborne said:

"Despite unrest, turmoil, wars and social changes in our times, there are many more stable and happy people and families than ever before."

Pointing to Wisconsin high emphasis on children's mental health, Dr. Osborne reminded readers that adult mental patients in the state's institutions "were yesterday's children".

"There are still many unfounded dreads, superstitions and attitudes which hurt both patients and the public. Medical progress has seen similar dreads and superstitions that surround 'consumption' give way to enlightened understanding, treatment and control of tuberculosis."

"We believe similar public education can go far to help win the battles for mental health now being waged," concluded Dr. Osborne.

AGING

AMA Conference

Moving ever more quickly to meet its special responsibilities to the 9% of the nation's population now over 65, the U. S. medical profession is sponsoring eight regional conferences on "positive health and life fulfillment for the aging."

The AMA, in cooperation with state societies of Wisconsin, Iowa, North Dakota, South Dakota and Minnesota, will help one such meeting October 14–15 in Minneapolis.

Headed by President Hildebrand and Dr. A. M. Hutter, chairman of the SMS Division on Aging, a cross-section of Wisconsin will attend: businessmen, farmers, labor leaders, clerics, government officials.

Conference aims are four:

1) Appraise the significance of the longer life span, adding years to life.

2) Relate positive health among seniors to psychological, physiological and economic factors, again adding years to life.

3) Explore realistically opportunities and needs created by a growing population of older persons.

4) Assess responsibilities of the individual and of both non-medical and medical groups in dynamic approaches to the new era of aging.

Summing it up, said the AMA: "All people need a *new* and *realistic* attitude toward aging!"

Speakers Available!

Program chairmen for county medical societies are urged to set up their schedules of meetings for the coming year.

Available as speakers are SMS President Hildebrand, Councilors and members of the Commission on Medical Care Plans.

Arrangements may be made through the SMS office or President Hildebrand, 59 Racine St., Menasha.

CIVIL DEFENSE

AMA Conference

The Tenth County Medical Societies Civil Defense Conference is being sponsored by the AMA's council on National Defense, Nov. 7–9 in Chicago.

The conference is designed to assist all medical and health personnel connected with disaster preparedness programs.

Workshop sessions will cover such recent disasters as the December, 1958, fire in Our Lady of the Angels school in Chicago (95 deaths, several hundred casualties) and the 1959 tornado in St. Louis (several fatalities, 300 casualties).

Speakers include former Wisconsinite, Dr. William S. Middleton, Chief Medical Director of the Veterans Administration.

For additional information on the conference contact Frank N. Barton, Secretary, Council on National Defense, AMA, 535 N. Dearborn, Chicago 10.

POISON CONTROL

Kenosha

OLympic 4–5311, Poison Information Center, Kenosha Hospital, Kenosha.

Madison

ALpine 6–6811, University Hospitals Poison Information Center, Madison.

Milwaukee

DIvision 4–7100, Poison Control Center, Children's Hospital, Milwaukee

SO YOU THINK WE SHOULD HAVE SOCIALIZED MEDICINE!

"Here's what is happening in one country which has governmental medicine."

"A great deal is being said in the United States these days about high medical costs, particularly the claim that these have been increasing faster than general living costs in the past seven or eight years.

"The American citizen who thinks that his medical costs are too high might be interested in a recent report from the German newsmagazine, 'Der Spiegel' (The Mirror).

"In West Germany 80 per cent of the population are covered by governmental medicine, 12.5 per cent by private insurance, 5 per cent have no coverage at all, and 2.5 per cent are covered by charity. There are income limits above which the individual cannot belong to the low-priced governmental system; it is estimated that 15 per cent of those who do are able to pay for their own medical care but they resort to various subterfuges, such as sending their chauffeurs to the pharmacy to call for their free medicine.

"A company employing 5,000 persons, ordinarily requests 5,000 sickness certificates per quarter, which means that every employe has at least one sick call in a quarter, whether he needs it or not; this is because the general attitude of the people is that they have paid for the system and they might as well get something out of it. Hospital expenses have increased because the average patient remains in the hospital for 38 days whereas prior to 1955, he remained there only 21 days.

The article reprinted on this page appeared in the July, 1959, issue of an employee publication of Snap-On Tools Corp., Kenosha. The quoted portion of the article concerns West Germany's brand of medicine-by-government, and is copyrighted by Columbia Features, Inc.

But Snap-On's sharp editor Dick Wehner went a step further: he called his insurance department, got figures on what the average Snap-On employee was paying for his health insurance, and, in the last paragraph, compared West Germany and Kenosha, Wis.

As any employee could see, deduced editor Wehner, "Free medicine isn't so free after all."

"The medical care system in Germany must pay each worker 90 per cent of his net salary for a maximum of six weeks while he is sick. During a recent influenza wave most parts of the system lost their reserves and ran into debt because everyone who had the flu was sick for at least 14 days, on 90 per cent of his working pay.

"This system, like others which are represented as free medicine, is far from free. Since 1956 when *6 per cent of a day's pay was deducted* for medical purposes, the deduction now *has increased to 8.5 per cent* and in some units to *10.5 per cent.* The German worker earning $165.00 a month contributes up *to $17.50* for his medical care. *His total deductions for social purposes* amount to *30 per cent of his pay.*

"The end result, according to this German paper, is that the mixed-up system of socialized medicine in Germany, largely dominated by the government, is bankrupt. Costs have risen, medical care has deteriorated, physicians are unhappy, and the general outlook is bad.

"It all goes to prove that you can't get something for nothing. Even at present relatively high prices, American medicine is still not only the best in the world but the least expensive."

On the basis of what the German worker contributes for medical care, the average *Snap-on* employe would be paying $10 per week if married with dependents, and $8.50 per week if single. The average *Snap-on* employe now is paying $1.52 per week if married and has two or more dependents; $1.19 per week if married with one dependent; and 60 cents per week if single. These rates include Life and Double Indemnity insurance, which is coverage not provided to the German worker.

BOOKS

Doctor at Sea

Amery is a tiny landlocked town in northwestern Wisconsin, easily a hundred miles from any sizeable body of sailing water, such as Lake Superior.

But Dr. Frederick L. Whitlark, of the local Cornwall Clinic has always yearned for the faraway Great Lakes. Born in Chicago, he worked each summer on Great Lakes shipping while going to the University of Illinois.

During the war he served as medical officer with the navy. Since then he has stole back to the vast inland seas whenever he could.

Recently when Queen Elizabeth and Prince Philip of Great Britain led dedication ceremonies for the newly-completed St. Lawrence Seaway, Dr. and Mrs. Whitlark managed to be on hand.

D. F. L. WHITLARK
"This different world afloat. . ."

It was a great occasion, and dignitaries were provided with copies of an appropriate book just off the press: *Introduction to the Great Lakes . . . and the St. Lawrence Seaway.*

Filled with maps, illustrations and information on our fourth seacoast, the authoritative book is designed "to introduce the casual harbor visitor or serious lake traveler to a basic understanding of this different world afloat."

The author: Frederick L. Whitlark, M. D.

THE WISCONSIN MEDICAL JOURNAL

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Allergic Cutaneous Vasculitis

Report of a Case

By ERNEST A. STRAKOSCH, M. D.
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WILLIAM B. HILDEBRAND, M. D.
Menasha, Wisconsin

THE PURPOSE OF this report is to call attention to allergic cutaneous vasculitis, which must be more common than it appears from the references to it in the American literature. [1, 2] The historical background and references were given by Irgang.[2] The eruption, which develops on an allergic basis, has a predilection for the lower extremities. It consists of macular and papular erythematous lesions, hemorrhagic macules, nodules, vesicles and bullae with and without erythematous halo. Some lesions may resemble those seen in erythema multiform and urticaria. As the condition progresses papulonecrotic lesions and small punched-out ulcers may be seen.

Report of a Case

A white male, age 40, was first seen by one of us (W.B.H.) on September 30, 1956, complaining of a tender, painful swelling of the right knee and both ankle joints, small blisters below the right knee, on the ankles of both legs, and on some of his toes.

The family history was negative. The patient had suffered from a dust allergy for the past 28 years, manifested by sneezing, coughing, and lacrimation. He also had developed asthma and hayfever in the spring and summer for the past two years.

The patient was hospitalized. The main findings were as follows: The right knee was red, tender, and swollen; there were four bullous lesions containing clear fluid below the right knee joint and small blisters were present over both ankles and on three toes of each foot. The hands and feet showed diminished sensation acuity. Laboratory data was: hemoglobin, 85%; red blood cell count, 4,320,000; white blood cell count, 8,750 (64% PMN, 16% lymph., 7% mon., 8% eos., 5% stab.), erythrocyte sedimentation rate, 54 mm/hr. Urine: repeatedly normal. The diagnosis was: cellulitis right knee, paresthesia of hands and feet of unknown etiology. He was treated with hot wet compresses and 600,000 units penicillin intramuscularly daily. He was discharged after four days at which time the right knee was of normal size and the skin lesions were drying.

The patient was again admitted to the hospital on October 16, 1956, for a generalized urticaria, which was believed to be due to penicillin which he previously was given. Laboratory data: hemoglobin, 84%; red blood cell count, 4,370,000; white blood cell count, 6,050 (65% PMN, 24% lymph., 1% mon., 4% eos., 6% stab.), erythrocyte sedimentation rate 5 mm/hr. He was given tripelennamine (Pyribenzamine) 50 mg. every four hours and discharged as cured on October 23.

He was again admitted to the hospital on November 8, 1956. Since the previous admission, he had developed pain in the right upper abdominal quadrant and jaundice, lasting for about 10 days. He had numerous small, rather painful nodules on his legs, some small blisters; and during the past 10 days he had developed two painful areas, the size of a silver dollar, on the posterior aspect of his right thigh. On examination his liver was slightly enlarged and tender. There were two large deep ulcers, exuding purulent pus,

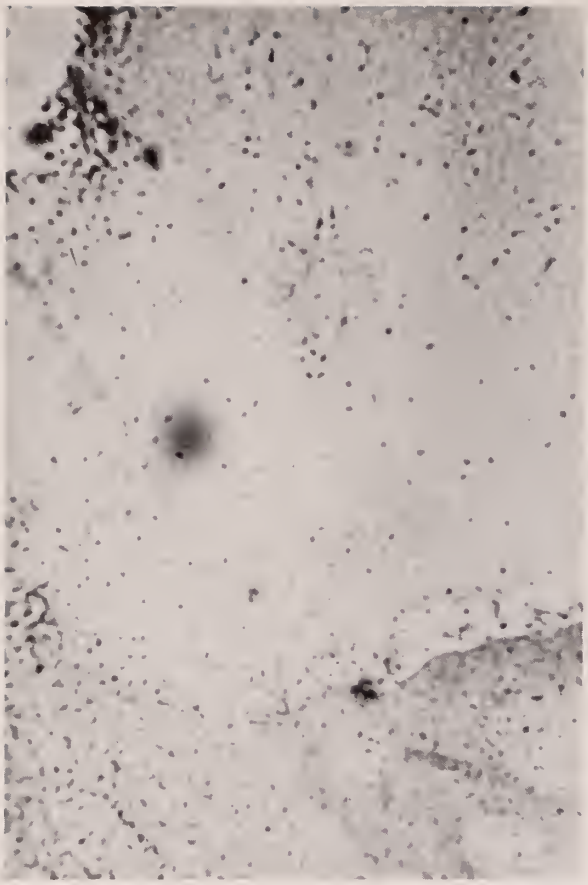

Fig. 1—Low-power photomicrograph showing vesicle containing eosinophils and plasma cells; eosinophilic infiltrate in epidermis.

on the posterior aspect of the right upper thigh. Numerous hemorrhagic macules, papules, and bullous lesions with and without erythematous halo were present on both legs, hands, and arms. There were small vesicles on six toes. There were hard painful nodular lesions around the medial aspect of the left ankle. A few punched-out ulcers and numerous round to oval scars were seen on the legs. Almost all finger joints were swollen and painful. The right knee joint and all foot joints were painful on motion.

The laboratory data were as follows: hemoglobin, 76%; red blood cell count, 3,830,000; white blood cell count, 6,700 (46% PMN, 41% lymph., 8% mon., 5% eos.); urine: negative on five examinations. All other findings were normal except for a slightly increased indirect van den Bergh reaction. Staphylococcus albus was cultured from the lesions on the thigh. The diagnosis was: probable periarteritis, residual infectious hepatitis. One of us (E.A.S.) was called in consultation because of the skin lesions.

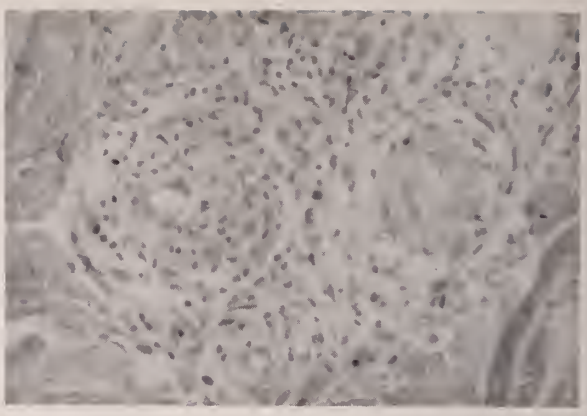

Fig. 2—High-power photomicrograph showing panateriolitis, degeneration of the thickened intima, and eosinophilic infiltrate.

Two biopsies were performed, one from a bullous lesion and one from a nodular lesion.

Histologic examination: Micro-sections through the bullous lesion showed the epithelium covered by a thin layer of keratin. The stratum granulosum was prominent. The bulla was filled with pale eosinophilic material and many eosinophilic polymorphonuclear leukocytes, lymphocytes and plasma cells. Similar smaller areas were present within the epidermis. The basal layer was intact. Sections through the nodular lesion showed a rather dense infiltrate throughout the epidermis, consisting of polymorphonuclear eosinophilic leukocytes. The walls of the vessels were greatly thickened, the intima of the affected arterioles was broadened and showed fibrinoid degeneration. The media of those vessels was also thickened. The pervascular areas and zones surrounding sweat glands and skin appendage structures were edematous and infiltrated with eosinophilic leukocytes, lymphocytes, and large mononuclear cells. The basal membranes of the skin appendage structures and of some vessels showed fibrinoid degeneration. There were focal areas of necrosis present in the muscle zones. The inflammatory infiltrate extended into the underlying fat tissue. The histologic picture was consistent with allergic vasculitis.

A section was sent to Dr. Hamilton Montgomery, of the Mayo Clinic, who wrote: "I am quite satisfied that the sections are not those of periarteritis nodosa. They would fit in with the so-called 'allergic angiitis'. There is thickening of the blood vessels and degenerative changes in the walls, but the changes are not those of a frank periarteritis nodosa. The infiltrate consists mostly of eosinophils."

The patient was given prednisone (Meticorten) 10 mg. every six hours. The dose was reduced after two days to 5 mg. four times a day and to 5 mg. three times a day after four days. He was discharged on November 22 at which time all the lesions were healed.

He was again seen on January 2, 1957, when he had nodular lesions on his right buttock. These cleared up after a few days of oral prednisone. He had another recurrence consisting of maculopapular lesions and a few small nodules on his legs in November 1957. These again responded quickly to prednisone. An allergic survey was negative except for positive skin tests to house dust and a few pollens. He has been free of any lesions since.

Comment

Rostenberg[3] believes that "allergic vasculitis" is primarily a pathologic diagnosis. We basically agree with him, but we do believe that the clinical diagnosis can be made if one becomes familiar with the picture the condition shows and if one thinks of it. Numerous cases, which were diagnosed clinically, have been reported by the European dermatologists.[2] The skin lesions are polymorphous in most reported cases. Irgang's[2] case showed only macules. The variety of skin lesions is most likely due to the severity of the immunologic reaction, the antigen-antibody union, as well as due to the developmental phase of the lesions observed. This is well demonstrated in our patient who had macular and papular lesions. Some became nodular, necrotic-forming, small ulcers. The large, secondarily infected ulcers on his thigh started as nodules.

Summary

A case of allergic cutaneous vasculitis is presented in a 40-year-old white male. The eruption consisted of macular, papular, nodular lesions and vesicular and bullous lesions with and without erythematous halo. The lesions were most numerous on the lower extremities, although there were some on the hands and arms.

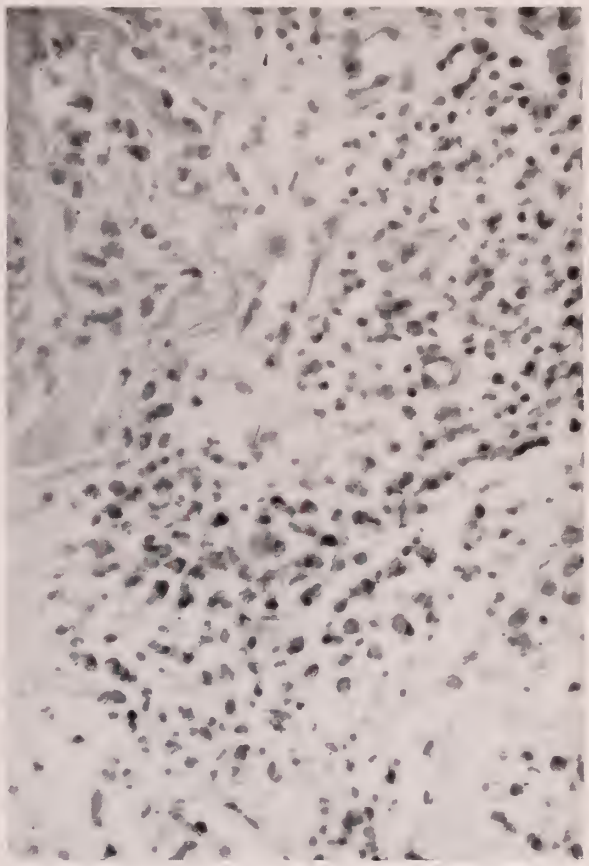

Fig. 3—High-power photomicrograph of the nodular lesion showing infiltrate consisting of eosinophils and plasma cells in the subcutis.

The outstanding histologic changes were: thickening of the vessel walls with fibrinoid degeneration and a dense infiltrate consisting of eosinophils, plasma cells and monocytes.

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Family Physician ⟷ Industrial Physician

Employee–Patient

A TWO WAY STREET

By JOHN ALLEN, M. D.*
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MUCH HAS BEEN written and much has been voiced regarding the proper place of industrial medicine in today's medical practice picture. Regardless of from which side of the fence you may see the employee-patient, it should be the utmost concern of the family physician and the industrial physician that this employee-patient be served with the best possible medical program. Actually, it is only when both in-plant and outside medical facilities are being fully employed, that the patient benefits most.

Occupational health specialists have never advocated the idea of assuming complete care of the employee-patient. Care for non-occupational injury or disease properly belongs with the family physician. Industrial medicine is rightfully concerned, however, with the prevention and, if not fully accomplished, the treatment of occupational illness and injury.

When John Doe, employee-patient, is ill or injured and away from the work place, many people are affected. The employer is faced with a missing link in his operational unit, the family is faced with providing necessities on a reduced income, and the employee must endure the anxiety and suffering commensurate with his or her disability. Naturally, the earliest return to work, compatible with sound medical judgment, is important to all parties concerned.

It is with this return-to-work problem that many well-meaning practitioners go astray. This usually takes the form of: (1) not allowing the patient to return to modified work which would be made specifically available and well within safety limits for him to perform, or (2) sending the patient back to the work place with so many restrictions as to activity that his usefulness to the company is practically zero.

Both of the above situations have one common basis and that is lack of understanding of what actually goes on in the work place. It is not expected that the family physician will have intimate knowledge of the place of work of his patient. This information, however, is at the fingertips of the industrial medical specialist and would be made available to the private physician for the asking. Thus, I am urgently requesting more communication between in-plant and outside medical services.

I should like to give an illustration of what I have referred to previously. Recently, a 35-year-old male received a simple fracture of the left radius. This accident occurred away from his place of employment. The attending physician estimated his period of disability at eight weeks. After some four weeks had elapsed, the industrial physician, through job evaluation with the employee's foreman, found that a safe one-armed job could be provided for this man. The attending physician was reluctant to change his period of disability estimate, but, after considerable discussion, released the patient to return to this one-arm job after five weeks of the disability period had elapsed, and everyone benefited.

Much more active communication between the private physician and the industrial physician as well as the employee-patient is needed. When this information moves more freely along this two-way street, employee, employer and physician will achieve greater satisfaction from a job well done.

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Large Hair Ball in Stomach of Male 58 Years of Age

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Boyd, Wisconsin

THE TERM BEZOAR as used today is applied to various concretions and foreign and intrinsic substances found in the stomach and intestines of both man and animals. Bezoars are classified according to their composition: 1. Trichobezoar (hair ball); 2. Phytobezoar, a. Diospyrobezoar (persimmon ball), b. other vegetable material; 3. Trichophytobezoars (hair and vegetable material); 4. Concretions (shellac and materials).

From 311 cases of bezoars reported by DeBakey and Ochsner,[1] 172 cases (or 55.3%) were trichobezoars, 126 cases (or 40.4%) were phytobezoars, and 13 cases (or 4.3%) were concretions.

It is generally considered that the swallowing of hair and the formation of trichobezoars is an expression of personality maladjustment, such as nail-biting, enuresis, tics, etc. Hair balls are produced gradually by the hair being caught in the gastric folds and the formation of a mass. The cause of the formation of other types of bezoars like phytobezoars is not definitely known. It is thought that men in the southern states eating a large amount of persimmons, and the formation of persimmon balls, make up the bulk of cases having phytobezoars. The American persimmon grows chiefly in the southeastern states where it ripens in the late fall and is edible after being tenderized and sweetened by frost and freezing weather. The eating of wild persimmons by hunters is often the cause of bezoar formation.

Concretions are a result of a chemical process. For example, shellac is soluble in alcohol and insoluble in water. After the ingestion of shellac, concretions form due to the absorption of the alcohol and precipitation of the shellac with water.

The symptoms of bezoars depends largely on the composition. The symptoms produced by trichobezoars begin as vague gastrointestinal disturbances characterized by nausea, vomiting, epigastric pain, weight loss, weakness, constipation, and diarrhea. Later paroxysmal attacks of pain, with or without nausea and vomiting, may occur. Complaints of this condition including perforation, obstruction, or starvation, will produce corresponding signs and symptoms. It is evident that the symptoms of trichobezoars are gradual in developing because their formation is gradual over the years. On the other hand, the symptoms of phytobezoars, especially persimmon balls, are usually much more fulminating. The patient dates his complaint to a relatively short period of time, a few hours to several days, after eating a large quantity of persimmons. The symptoms of other bezoars mentioned above are also of rather sudden onset.

The sex and age distribution of trichobezoars is clearly demonstrated by the series of collected cases in which over 90% were females and over 80% under the age of 30 years. The largest trichobezoar ever reported was by Davies.[2] It weighed 6.5 pounds immediately on removal. The hair ball usually conforms to the shape of the stomach. A few have had a hair ball in the small bowel. The odor is always described as foul, presumably owing to the partially decayed food stuff trapped between the inter-twining hairs. The color, even in blond patients, is always dark greenish brown or black from the chemical action of the gastric contents on the hair.

Recurrences are not uncommon. Harris[3] described a woman who had five trichobezoars removed during a 13-year period. Recently Chaudhuri[4] removed two hair balls from the stomach of a 9-year-old girl within 21 months. The second trichobezoar weighed 1 kg., or more than 2 pounds, on removal. Mullen[5] reviewed the literature through

Fig. 1—The trichobezoar which was removed from the patient's stomach, plus smaller one which appeared following operation.

1954, and added another case to bring the number of reported cases of trichobezoars to 212. Since that time reports of at least 18 cases have appeared in the literature, bringing the number to 230. Hoyt *et al.*[6] presented a case in September 1958, and stated that this is the only one in which a diagnosis of trichobezoar has been made at the Mayo Clinic since 1950.

The most important information from the history is that of trichophagia, or swallowing of hair. The physical findings are nondiagnostic and in 87.7% of the cases they include a palpable mass in the epigastrium. The mass is firm with well defined borders and is usually nontender and fairly movable. It may move with respiration. Laboratory examination is not helpful except for x-rays of the stomach with barium. Frequently hair may be found in the stool.

Case Report

Our patient, a male 58 years of age, was admitted to the hospital on December 2, 1958, with rigidity and tenderness in the upper abdomen. He admitted having had nausea, vomiting, and gas distress for about 3 or 4 days. There had been some colicky pain in the left upper abdomen over a period of about 8 months.

The patient was well nourished and developed. We found that in the upper abdomen, especially in the epigastric area, there was much tenderness and board-like rigidity of the anterior wall so we were unable to palpate any internal organ or tumor. The blood count was as follows: red blood cell count, 5,600,000; white blood cell count, 14,000; and hemoglobin, 16 gm. The hematocrit was 66%. X-ray examination was done by the mobile unit because of the state of extremis of the patient.

We took only a flat plate in which not too much was found by inspection. No attempt was made to have the patient ingest barium because of his serious condition. In retrospect and after re-examination of the x-ray film of the area of increased density in the region of the stomach, it was believed that this area represented the bezoar which was found at operation. The preoperative diagnosis was bowel obstruction of unknown cause. The postoperative diagnosis was trichobezoar of a large size.

At operation an upper rectus paramedian incision was made. A solid mass filling the entire stomach was palpated. The remainder of the abdomen seemed to be normal. An anterior gastrotomy was performed. Following removal of the mass, the gastric mucosa appeared to be smooth and healthy. In fact, we thought it was smoother than normal but there was no indication of ulceration or bleeding from the mucosa. The stomach was repaired with inverting and hemostatic sutures of continuous chromic 00 catgut. This was reinforced by one row of interrupted cotton sutures. The pathologic report from the State Laboratory of Hygiene was: "Hair of human origin".

This patient had a very stormy postoperative course and remained in the hospital about six weeks. He maintained a very high hematocrit and appeared to have obstructive symptoms. He had gastric suction continuously for about two weeks and was given a very large volume of electrolytes with poor response. What seemed to be most specific for his condition was the giving of blood plasma which did the most to correct the abnormally high hematocrit that this patient tended to retain postoperatively.

On December 15, 1958, even though he appeared in fairly good physical condition, he had a complete dehiscence of the wound. The wound was closed with a continuous suture of the peritoneum and the transversalis fascia. Then we used many interrupted

through-and-through sutures of braided steel wire for the rest of the abdominal wall. A few interrupted sutures of silk were used for coaptation of the skin edges.

Since the patient left the hospital his course has been uneventful and he has returned to his usual occupation as laborer in a lumber yard.

Discussion

The hair ball, or trichobezoar, in our case appears to have been caused by a mental aberration in our patient. He relates that during the war years he spent his time on the west coast working in a war munitions plant. He was separated from his wife during this time because she remained at home in her own community. He states he was jealous of her and suspected her of being unfaithful to him, and that he received sexual satisfaction by eating human hair. He has refused to reveal the source of the hair. The trichobezoar which we removed from our patient's stomach is shown in figure 1. It measured 19 cm. at the greatest length and 9 cm. at the largest width. It was shaped exactly like the stomach. There was also another smaller trichobezoar which the patient passed about a week after the removal of the trichobezoar from the stomach. This small one may have caused some obstruction because the patient had considerable difficulty following surgery. This trichobezoar measured about 7 cm. by about 2 cm.

Summary

1. Report is made of the successful removal of a large hair ball in a man age 58 years. Our case makes 231 cases reported in literature.
2. Because of the rarity of its occurrence the preoperative diagnosis of hair ball is usually missed.
3. Physical findings are nondiagnostic because signs simulate other conditions. A palpable mass in abdomen with a typical history should suggest diagnosis. X-ray examination with barium is helpful.
4. There is a typical symptom pattern because symptoms are produced by the presence of a foreign body within the stomach.

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New Communicable Disease Control Rules

By CARL N. NEUPERT, M. D.*

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THE WISCONSIN STATE Board of Health recently approved a number of changes in the rules governing the control of communicable diseases which became effective October 2, 1959. A great number of changes were made only in the wording of the rules for clarification. However, there were a number of changes which may be of interest to practicing physicians.

Two new disease entities have become reportable. One of them is Q fever, a newly recognized disease, which is of importance in a dairy-producing state such as Wisconsin. Reporting will make it possible to trace the source of this infection and prevent further spread.

The other new disease group also made reportable is viral (aseptic) meningitis. In the past this group of diseases was often reported as non-paralytic poliomyelitis or as complications of measles, chickenpox, etc. The newly recognized viruses now can be identified with the aid of laboratory tests. Reporting will make it possible to study these diseases in detail so that their clinical, epidemiologic, and public health significance will be better understood. The reporting terminology to be used is: (1) Viral or aseptic meningitis, *primary;* and it is requested that the etiology be given such as poliomyelitis, E.C.H.O., Cocksackie, lymphocytic choriomeningitis, unknown, etc. (2) Viral or aseptic meningitis, *secondary;* and it is requested that physicians also name the underlying disease such as measles, mumps, chickenpox, etc.

Recent advances in virology have established new facts about the periods of communicability of certain common diseases. It is now known that German measles is not communicable 18 hours after the rash appears, so the previous requirement of restriction for school children has been shortened from 7 days to 3 days (counted from the onset of symptoms).

With the development of effective new antibiotics, a number of contagious disease requirements have become obsolete. These drugs are very effective in terminating the contagiousness of certain infections within a short time after administration. We can now release a patient with streptococcal infection 24 hours after a depot-type penicillin has been administered. The same principle is applicable to persons working in milk production who are exposed to scarlet fever. If such a person is disassociated from a case of streptococcal infection and has had a depot penicillin injection, he may participate in milk production. The meningococci are easily eliminated from a patient by use of "sulfa" drugs or other antibiotics. Therefore, the isolation period requirement has been shortened to 48 hours for those patients using such medication.

On the other hand, antibiotics have also created a problem in releasing patients with enteric fever infection (typhoid, paratyphoid, salmonellosis, etc.). It is requested now that for release purposes in enteric diseases stool cultures should be taken on specimens obtained at least 7 days after the last dose of an effective antibiotic.

Vincent's angina was deleted from the list of diseases requiring exclusion from school attendance because we now know that this disease spreads only by mouth-to-mouth contact. It was also felt that in cases of ringworm of the body there is practically no danger of spread if the lesions are properly covered by fungicidal medication.

In other regulations special mention is made about employees in nursing homes. The recent growth in the number of nursing homes has made emphasis on protecting patients in such homes more advisable. The specific disease regulations for typhoid, paratyphoid, dysentery, and salmonellosis prohibit the employment of both cases and carriers in such institutions, and the admitting of persons with such diseases as patients.

Copies of the complete communicable disease rules are available on request to the Wisconsin State Board of Health.

* State Health Officer.

Echinococcosis

By T. W. Dorman, M. D. and E. S. OLSON, M. D.
Racine, Wisconsin

THE PURPOSE OF THIS paper is to present a case of echinococcosis in an immigrant and to review some of the pertinent features of this disease.

Hydatid disease was referred to in the Talmud. Hippocrates referred to water on the liver. The cause of these cysts was discovered in 1853.[1]

The infection is seen most often in sheep and cattle raising areas.

The echinococcus granulosus is the smallest tapeworm of medical importance. It ranges from 2.5 cm. to 9 mm. in length. It lives in the lower duodenum and upper jejunum. It has a scolex, neck, and three segments. The intestines invariably contain countless thousands of the worm. The ova contaminates grass and vegetables; the fur of the diseased animals is also infected.

The definitive hosts are usually the dog, wolf, jackass, and coyote. The common intermediate hosts are man, sheep, cattle, horse, hog, and other herbivorous animals. Five cases have been reported in Virginia in which the origin of the infection was considered to be in local hogs.[2] Moose and caribou have also been reported to be infected in Canada where the disease is considered to be endemic.[3] The adult worms have been found in timber wolves and the larval hydatids in moose in the United States.[4]

The ova from the feces are ingested by man or other intermediate hosts. The hexacanth embryo escapes in the duodenum and becomes attached to the mucosa by its hooklets. The embryo enters the lymphatics or venules and is carried to the liver, lungs, and other organs, where it develops into a hydatid cyst. This is the beginning of the larval stage. The embryonic hooklets disappear and the cyst increases in size. It measures approximately 10 mm. in diameter in five months.

The enveloping membrane is gradually differentiated into an external laminated layer which is an ectocyst. It is produced from the outer surface of the germinal layer. The lamellated layer permits nutrition to enter the cyst, but prevents harmful agents from reaching the inner portion. The internal layer is the endocyst or the nucleated germinal layer. This is the parasite itself. The germinal layer gives rise to brood capsules. These are small papillae and are equipped with suckers and a double crown of hooks. They represent the maturity of the larval parasite. When the capsule ruptures, the scolices escape into the hydatid cyst and are known as "hydatid sand." This is considered a fertile cyst.[1]

When the hydatid is eaten by a definitive host such as the dog, it develops into a sexually mature worm in about seven weeks.

There are three types of hydatid cysts seen in man: unilocular, osseous, and alveolar.

The unilocular cyst is the most common form. They grow slowly and require several years for development. They vary in size. In many instances they reach a diameter of 15.0 to 20.0 cm. The surrounding tissue contains fibroblasts, eosinophils, and giant cells. The inner surface of a fertile cyst is studded with the brood capsules. Hydatids without brood capsules and scolices are called sterile cysts.

The daughter cysts have a thin transparent wall and are often free in the cystic fluid which was true in the case we are presenting. These cysts may arise from the germinal membrane, brood capsule, or from scolices. Granddaughter cysts may develop within the daughter cysts. This is particularly true in hepatic cysts of man.

The osseous cysts grow along the bony canals with erosion and invasion into the medullary cavity. Spontaneous fracture is common. There may be a pseudotuberculous reaction with foreign body giant cells present.

The alveolar cysts grow similar to a neoplastic tumor. It is not well circumscribed and invades the surrounding tissue. It gives rise to metastases in other organs.

The cysts may involve any organ, but in man are usually single and confined to one

organ and is fertile. A recent case of multiple hydatid cysts that involved the liver, lungs, and endocardium was reported.[5] The endocardial cyst ruptured into the right ventricle. The liver is the most common organ involved and the lung is next in frequency. A case that involved the myocardium was recently reported and treated successfully by surgical means.[6] Recently there have been reported two cases, involving the pericardium, which were successfully treated surgically.[7] One case was reported in which the daughter cysts caused obstruction to the common duct.[8]

Hepatic cysts have been reported to become infected with salmonella and pyogenic bacteria. In our case, Escherichia coli were grown on two different occasions from material from the hepatic cyst obtained by needle biopsy. The infection may render the cyst sterile.

The symptoms depend on the location and are those of a slowly growing tumor. The infection is usually acquired in childhood, but symptoms develop much later in life. The prognosis is good when the primary cyst is accessible to surgery.

Skin tests are employed. The antigen usually consists of sterile hydatid fluid. Possibly the most specific skin test may be obtained by using the polysaccharide portion of the antigen extracted from hydatid scolices.[9] Complement fixation tests have also been used. It is said that there are no false tests. However, this test was negative in our case. The bentonite flocculation test might be helpful. It had a positive reaction to a dilution of 1–160 in our case. This test is in the experimental phase. It should be pointed out that exploratory punctures can be dangerous as secondary echinococcosis and anaphylactic shock may result.

The treatment is surgical. Chemotherapy is not effective. The safest procedure is to exteriorize the cyst and ten days later go through the exteriorized area and inject 40% formaldehyde (Formalin) or absolute alcohol. This kills the cysts. The ectocyst is then incised and the endocyst is removed. The chitinous layer may act as a foreign body if it is permitted to remain. A calcified cyst should be left alone.[1] Preventative measures have been effective. This is accomplished by preventing dogs from being contaminated. It has been estimated that up to 32% of the stray dogs are affected in endemic areas.

Case Report

The patient was an emaciated 62-year-old male who complained of a "cold in the abdomen" and anorexia. He herded sheep as a boy in Bulgaria. A detailed history could not be obtained because of language difficulty.

He appeared chronically ill, but in no acute distress. The blood pressure, pulse, respirations, and temperature were normal. There was dullness and absence of breath sounds at the base of the right lung. The heart was normal. The abdomen was distended. The liver was palpated four fingers breadth below the costal margin. The edge of the liver was round, smooth, and slightly tender. The spleen was not enlarged.

An x-ray of the abdomen showed the liver to be enlarged. A planograph showed the liver to be homogenous. The right diaphragm was elevated. The stomach was displaced to the left by the large liver.

The blood nonprotein nitrogen was 52. The Bence-Jones protein test was negative. The transaminase was 100 units. The bromsulphalein test showed a 14% retention. The indirect van den Bergh test was within normal limits. The thymol turbidity test was 3.1. A complement fixation test for echinococcosis was negative. A similar test for amebiasis was not available. The urinalysis showed a 2 plus albumin and an occasional granular cast. The bentonite flocculation test was positive to a dilution of 1–160. This test is in the experimental stage for echinococcosis as noted above. The creatinine, calcium, carbon dioxide, chlorides, alkaline phosphatase, and potassium were normal. The red blood cell count was 3,600,000 on admission. The white blood cell count was 8,400. The differential showed 64% polys, 6% bands, 14% lymphs, 14% monos, and 2% eosinophils. A bone marrow culture was negative. Cultures from two different liver biopsies showed Escherichia coli. Laminated material was seen on the section. Electrocardiograms were negative.

The patient had a slightly elevated temperature. It was decided to explore the abdomen even though the patient was not in good condition. Echinococcosis was considered as a possible diagnosis, but the negative complement fixation test tended to exclude this condition. The exploration was performed seven weeks after he entered the hospital. Two thousand cc. of echinococcus cysts were obtained. (Fig. 1).

Fig. 1—Photograph demonstrating a portion of the hydatid cysts removed at the time of surgery.

The patient received 21 blood transfusions. Most of them were given to prepare the patient for surgery and during his surgical procedure. The patient gradually improved and left the hospital against medical advice 11 weeks after surgery.

Summary

Echinococcosis is autochthonous in the United States. Pigs have been the source in one instance. The condition occurs more frequently in Canada where moose and caribou may be the source of infection. The condition is most frequent where herbivorous animals, which are the intermediate hosts, are herded. They are sheep, cattle, horses, and other herbivorous animals. The definitive hosts are usually dogs, wolves, jackass, and coyotes. The ova from these animals are ingested by the intermediate hosts. Hydatid cysts develop in the various organs. The various types of cysts encountered clinically are outlined. The complement fixation test for echinococcosis was negative in this case. The bentonite test was positive. The treatment was surgical.

St. Luke's Memorial Hospital.

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Over Half Million Have Cerebral Palsy

About 3 in every 1,000 Americans has cerebral palsy, according to the current issue of *Patterns of Disease*, a Parke, Davis & Company publication for the medical profession. The disease ranks below two other neurological disorders—epilepsy and Parkinson's syndrome—but occurs more often than multiple sclerosis and twice as often as muscular dystrophy. Over half a million persons in this country are afflicted by cerebral palsy but, *Patterns* notes, "the classification is very broad and may include disorders arising from brain lesions from any cause including cerebral hemorrhage in the aged." If these disorders of the adult brain are included, the incidence of cerebral palsy is estimated at 2,500,000 persons.

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Radiation Therapy in Breast Cancer*

By HALVOR VERMUND, M. D.** and CHARLES BENKENDORF, M. D.***

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THE INCREASING NUMBER of deaths from cancer of the breast represents a great challenge to the medical profession and has in many institutions necessitated a review of certain treatment policies, particularly regarding indications for surgery and radiotherapy in tumors extending beyond the confines of the breast.

The Special Report from the U. S. Public Health Department on Vital Statistics for the year 1956[1] gives a mortality rate of 26.0 per 100,000 population, or 22,054 female deaths from breast cancer, which is the highest so far reported for any one year.

The radical mastectomy as perfected by Halsted and co-workers yields good results in tumors confined to the breast. Unfortunately relatively few patients can be classified in this category when referred for treatment. This fact emphasizes the need for earlier diagnosis, and any procrastination in referring a patient with a tumor in the breast for definitive diagnosis and treatment is inexcusable in modern medical practice. Considerable progress in the field of hormone and chemotherapy has provided valuable adjuncts in the palliative therapy of advanced breast cancer but cannot be relied upon for curative treatment.

Radiation therapy has played a significant role in the management of breast cancer. Its value as a palliative agent is well recognized, but there is considerable disagreement regarding the extent to which irradiation should be depended upon for curative treatment. Therefore, no uniformity of opinion exists as to dosage, technics and fractionation schemes. Contributing to the confusion on this subject is the fact that there is no general agreement as to the indications for radical mastectomy. Although most physicians agree that surgery is indicated if the cancer is operable, the criteria for operability and the types of operations vary greatly.

Seemingly wide differences of opinion regarding the role of radiotherapy in breast cancers are to a certain extent correlated with the type of operations performed in the particular institutions. In some hospitals the principle of careful selection of patients for a very meticulous radical mastectomy using clinical and histologic criteria has been chosen.[2] In others more emphasis has been placed on radiotherapy, and the operative procedure has been reduced to a simple or partial mastectomy in most patients with operable or locally advanced breast cancer.[3] In between there are many institutions which practice different modifications of the classical Halsted mastectomy and add postoperative radiotherapy with more conservative dosage in cases with axillary node metastases.[4]

Haagensen[2(a)] has developed a treatment plan, the aim of which is to operate only on patients in whom the cancer can be removed completely; and in these patients no postoperative prophylactic radiotherapy is given. The selection of patients is based on a thorough clinical and roentgen examination and in many patients on biopsies of the internal mammary, supraclavicular and apical axillary lymph nodes. Patients who show certain unfavorable clinical signs (fig. 1) or have histologic evidence of tumor extending beyond the tissues which can be removed are not operated upon but referred for radiation therapy and/or hormone therapy. Radical mastectomy is believed to be of no benefit to such patients and might shorten their lives. Haagensen has reported statistical evidence to support this opinion: Radical mastectomy in 1,015 clinically *operable* patients produced a five-year cure rate of 47%, while the same operation in 120 clinically *inoperable* patients resulted in only one patient alive for more than five years.[2(b)]

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Patients of all age groups with carcinoma of the breast who are in satisfactory physical condition should be treated by radical mastectomy except when:

1. Extensive edema of the skin over the breast is present.
2. Satellite nodules are present in the skin over the breast.
3. The carcinoma is of the inflammatory type.
4. Parasternal tumor nodules are present.
5. Proved supraclavicular metastases are present.
6. Edema of the arm is present.
7. Distant metastases are demonstrated.
8. Any two or more of the following grave signs of locally advanced carcinoma are present:
   a. Ulceration of the skin.
   b. Edema of the skin of limited extent (less than one-third of the skin over the breast involved).
   c. Solid fixation of the tumor to the chest wall.
   d. Axillary lymph nodes measuring 2.5 cm. or more in transverse diameter.
   e. Fixation of axillary lymph nodes to the skin or the deep structures of the axilla.

Fig. 1—Haagensen's clinical criteria of operability.[2(a)]

Handley[5] performed biopsies of the internal mammary lymph node chain in patients subjected to radical mastectomy for breast cancer. He found that 37 out of a total of 119 patients with axillary node metastases had simultaneous metastatic involvement of the internal mammary lymph nodes. Andreassen and Dahl-Iversen[6] reported that 11 out of 40 patients who had small mobile breast cancers with axillary node metastases showed microscopic evidence of tumor in the supraclavicular lymph nodes even though these could not be palpated clinically. In an additional 11 patients locally advanced breast carcinoma and axillary node metastases were found. None of these had palpable supraclavicular nodes; nevertheless 6 of them had microscopic evidence of metastases in the supraclavicular nodes upon biopsy.

Wangensteen[7] has estimated that approximately 60% of all patients with breast cancer and axillary node metastases have tumor beyond the axillary lymph nodes. Haagensen[2(c)] found that of 156 patients admitted for breast cancer to the Presbyterian Hospital in New York about 50% were inoperable because of local extent or distant spread of the tumor.

These figures illustrate the fact that a large majority of patients with carcinoma of the breast admitted to a general hospital cannot be cured by radical mastectomy alone. Attempts at extending the operation to dissection of internal mammary, mediastinal and supraclavicular lymph nodes have not yielded encouraging results because of high operative mortality and morbidity as well as high recurrence rate. The question is then raised whether radiotherapy might save some of these patients who cannot be cured by surgery alone.

Radiotherapy

Since many breast cancers are relatively radioresistant and have the tendency to spread widely to regional lymph nodes, several surgeons have doubts as to the efficacy of radiotherapy in eradicating residual tumor. In many instances such opinions are based upon experiences derived from studies on patients given low doses of x-ray therapy with inadequate technics.

Engelstad[8] reported on the histologic effects of radiation in 92 patients with breast cancer treated with epidermicidal doses followed by mastectomy three to eight weeks later. In 17 patients complete destruction of the tumor was demonstrated. In 40 additional patients the excised tumor showed marked radiation effects and in some of these ultimate complete eradication of the cancer might have been anticipated. McWhirter[3] has emphasized the need for adequate dosage of radiation to all tissues potentially involved with cancer including the chest wall and the regional lymph nodes. In a series of patients who had locally advanced breast cancer treated with simple mastectomy and postoperative x-ray therapy, he obtained a 46% five-year survival rate in 90 patients who had the relatively high minimal tumor dose of 3750 r in two to three weeks. By comparison the five-year survival rate was only 29% in a group of 41 comparable patients treated with a lower radiation dose given over a similar length of time.

In a group of 129 patients with supraclavicular node metastases from advanced breast cancer, McWhirter[9] reported a 17% five-year survival following simple mastectomy and

radiotherapy. These data suggest that radiotherapy in adequate dosage contributed to long-term survival in some patients with advanced breast cancer and is capable of destroying cancer in lymph nodes and tissues inaccessible to the surgeon. Based upon long experience with several thousand patients McWhirter recommends postoperative x-ray therapy with a minimal tumor dose of 3750 r over two to four weeks.

He uses opposing tangential fields to the anterior chest wall including the internal mammary chain of lymph nodes and opposing anterior and posterior fields to the supraclavicular and axillary areas. By this technic pulmonary radiation fibrosis can be avoided in most patients. McWhirter emphasizes that his method is applicable to the large majority of patients with breast cancer regardless of classification (fig. 2). It should be pointed out that included in Stage I there are undoubtedly many patients with metastatic involvement of axillary lymph nodes, microscopically, who would therefore be classified as Stage II by others. It is well known that the clinical appraisal of the presence or absence of lymph node metastases is very inaccurate. This is illustrated by figures collected from the University of Minnesota Hospitals by Stone and Vermund:[10] In a group of 87 patients who had no palpable axillary nodes, 55 showed microscopic evidence of cancer cells in the axillary nodes by examination of the specimen removed by radical mastectomy a short time afterwards. Similar results have been published by others.[11] Even the pathologic examination of the axillary content may be inaccurate unless a large number of nodes are sectioned and the histologic slides are studied carefully.[12] Haagensen[2(d)] found that in a group of 67 patients who had only one or two axillary nodes involved with metastatic breast cancer, 44 survived well for five years or more after radical mastectomy alone (66%). By comparison, in a group of 61 patients with 8 or more axillary nodes involved with metastases, only 9 survived well for five years (15%) after radical mastectomy without postoperative radiotherapy.

Engelstad[8] has administered dose levels as high as 3500 to 4000 r on the skin over a 10 to 12 day period with x-rays and over 6 to 7 days with a radium mold at a distance of 3 cm. between the skin and the radium. Teleradium was used over the supraclavicular fossa.

I. Growth confined to breast with or without involvement of small area of skin directly over the tumor
II. As I., with palpable mobile lymph nodes in axilla
III. Growth beyond corpus mammae
  (a) Large area of skin invaded
  (b) Tumor fixed to underlying muscle with or without mobile axillary nodes
IV. Growth beyond breast area
  (a) Fixation of axillary nodes
  (b) Tumor completely fixed to chest wall
  (c) Palpable lymph nodes in supraclavicular region
  (d) Skin nodules outside breast
  (e) Metastases opposite breast
  (f) Distant metastases

Fig. 2—McWhirter's staging of breast cancer.

The time interval between the mastectomy and the first radiation treatment may be of some importance. Most radiotherapists now recommend shortening this period as much as possible without interfering with the healing of the wound. Microscopic foci of tumor cells and tumor cells transplanted in the wound during the surgery may be destroyed with a lower dose than that required to eradicate larger tumor masses. Experimental studies with transplanted breast tumors in mice support such opinions.[13]

Preoperative radiotherapy may be of value in certain cases, particularly those on the borderline of operability.[14]

Comparison of Methods

In order to determine which method gives the best results we have to rely on statistical data. Survival figures from different institutions cannot be compared, however, unless the groups of patients for comparison have breast cancer of similar extent, histology, and biologic behavior. Unfortunately, there is no generally accepted international classification or staging of breast cancer. A patient who is considered operable in one institution may be turned down for radical mastectomy in another. Furthermore, the end points or the five- or ten-year survival rates studied may not be synonymous with the cure rates. One method may give a higher five-year survival rate, but a relatively high proportion of those surviving may still harbor the disease which may become activated at a later date. The treatments may have re-

TABLE 1—FIVE-YEAR SURVIVAL WITH BREAST CANCER

	Stage I and II Operable			Stage III and Stage IV Locally Advanced Tumor Beyond Breast Area			Total		
	No.	Alive	%	No.	Alive	%	No.	Alive	%
McWhirter[3]	1063	612	58	819	174	21	1882	786	42
Haagensen[2]	495	293	59	173	27	16	668	320	48
Engelstad[8]	772	495	64	612	60	10	1384	555	40

TABLE 2—TEN-YEAR SURVIVAL OF PATIENTS WITH OPERABLE BREAST CANCER—STAGE I AND II

	No.	Alive 10 years	
		No.	%
McWhirter[3]			
Edinburgh	254	99	39
Haagensen[2]			
New York	216	95	44
Engelstad[8]			
Norway	330	138	42

tarded the growth and the spread of the cancer, but have not been able to eradicate the disease. Selection of only the most favorable cases for a certain type of therapy leaving the rest to some other method of treatment may greatly bias the survival figures.

The goal must be to develop methods of treatment which can be applied to the greatest number of patients with the best possible long-term, symptom-free survival rates.

Keeping all the reservations regarding comparison of statistics in mind, it is still of interest to note the similarity of the five-year and ten-year survival figures of patients treated for breast cancer in different institutions (table 1). McWhirter's figure of 58% five-year survival rate in Stage I and II cases, referred to as operable but otherwise unselected, was achieved with simple mastectomy and heavy postoperative x-ray therapy.[3] Haagensen's figure of 59% five-year survival rate was obtained on carefully selected material treated with a very meticulous radical mastectomy without postoperative irradiation.[2(e)] Engelstad's figure of 64% five-year apparent cure rate was obtained on material considered operable, but otherwise unselected. In different hospitals radical mastectomies had been performed by many surgeons who then referred the patients for postoperative heavy radiation therapy. Harrington[15] reported a 50.6% five-year survival rate (3,870 out of 7,445 unselected patients) using radical mastectomy as the primary means of therapy and postoperative radiation therapy with conservative dosage in most but not all patients. This group included many patients who probably would have been recorded as locally advanced in McWhirter's classification and inoperable according to Haagensen's classification.

The ten-year survival figures from the same institutions are given in table 2. It is apparent that McWhirter, Haagensen, and Engelstad report very similar figures varying between 39 and 44% alive at the end of ten years.

Ackerman[16] studied the hospital charts and histologic sections of 719 patients who had been treated by McWhirter for breast cancer and had survived more than five years. He could verify the histologic diagnosis of cancer in all except 13 cases. Exclusion of these cases did not alter the five-year survival figures significantly. Local persistence of tumor was found in 49 out of 332 cases classified as Stage I and in 41 out of 223 cases recorded as Stage II (16%). In the locally advanced cases (Stage III) 17 out of 93 cases showed local persistence of tumor. In Stages I and II 555 cases were studied and only 380 (or 68%) of these were living and free of disease at the time of the report. Twenty seven patients were living with cancer and 104 had died with cancer more than five years after the treatments. The remaining 44 patients had died from supposedly intercurrent disease. Thus, approximately 24% of those patients surviving more than five years had either died from or were living with breast cancer. Corresponding figures for selected patients treated with radical mastectomy alone are not available, but according to statistics presented by Haagensen there is a difference of 15% between the five- and the ten-year survival figures. Thus, of 100 patients undergoing radical mastectomy 59 were alive and apparently free of disease at the end of five years. Of these 59 patients 15 might be expected to die during the next five years (=25%).

In a study of case material treated at the University of Minnesota Hospitals, Stone and Vermund[10] reported that 98 out of 209 patients classified as operable were known to be alive at the end of five years (=47%). Many patients considered inoperable according to the clinical criteria established by Haagensen and locally advanced according to McWhirter's classification, were included in this material. This figure is surprisingly similar to the 48% five-year survival reported by McWhirter for the combined oper-

Table 3—Total Number of Cases—1946–1951

Year	GROUPS					Total
	I	II	III	IV	V	
1946	13	13	2	7	2	37
1947	6	13	4	4	7	34
1948	4	20	1	1	5	31
1949	4	17	3	0	5	29
1950	6	19	1	1	5	32
1951	5	18	2	0	10	35
	38	100	13	13	34	198

Table 4—Presenting Symptoms

	Total Number	Percentage
Mass in Breast	171	86.4
Mass in Axilla	23	11.6
Diffuse Enlargement	6	3.0
Retraction of Nipple	9	4.5
Discharge from Nipple	7	3.5
Bleeding from Nipple	8	4.0
Reddening and Warmth of Breast	1	0.5
Mass in Supraclavicular Fossae	1	0.5
Distant Metastases	5	2.5

able and locally advanced groups (Stage I, II and III; 774 out of 1,609 cases).

Analysis of Case Material

The total number of patients with breast cancer referred for radiotherapy at the University of Wisconsin Hospitals over a six-year period were analyzed (table 3). All patients had been treated more than five years prior to this analysis and could therefore be included in the computation of the five-year survival rate. Three patients lost to follow-up were considered dead of cancer.

Classification. The patients were classified in five groups as follows:

Group I: 38 patients treated with radical mastectomy and postoperative roentgen therapy for carcinoma confined to the breast. The axillary nodes were free of metastases on microscopic examination (Stage I).

Group II: 100 patients with axillary lymph node metastases confirmed by histologic examination treated with radical mastectomy and postoperative roentgen therapy (Stage II).

All patients in group I and II had the diagnosis of cancer verified histologically by pathologists at the University Hospitals or State Laboratory of Hygiene.

Group III: 13 patients referred for postoperative roentgen therapy by surgeons outside the University Hospitals. Most of these patients had been treated with radical mastectomy but the records were lacking the information necessary for classification.

Group IV: 13 patients who were inoperable either because of the local extent of the tumor or distant metastases and were given radiotherapy sometimes with the addition of hormones.

Group V: 34 patients with recurrent breast cancer referred for palliative radiotherapy.

Thus of a total of 198 cases 151 (76%) had been treated with radical mastectomy and postoperative roentgen therapy.

Symptoms and Signs

The presenting symptoms are given in table 4. In some patients two simultaneous symptoms were recorded. A mass in the breast is by far the most common symptom which brings the patient to her doctor but occasionally distant metastases may precede the discovery of the primary tumor. A mass in the axilla was noted as the first symptom in 23 of our patients.

The technic of irradiation as developed by Pohle is illustrated in figure 3. Each of three fields to the anterior chest wall, axillary and supraclavicular regions received a dose of x-rays which usually amounted to 1600 r/air in 8 to 9 days. Patients who had involvement of the axillary nodes were treated with an additional posterior axillary field which also received 1600 r/air over the same period of time. The anterior chest field was treated with a quality of radiation corresponding to 0.2 mm. of copper half value layer; the axillary and supraclavicular fields with a half value layer of 1.05 mm. of copper. All fields were treated daily at a focal-skin distance of 50 cm.

The treatment series was repeated after 3 months in many of the patients and in some a third series was given 3 months later. The dose in the second and third series was frequently reduced to 1200 r/air to each field. In some patients the dose in the first course was increased to 2400 r/air over 12 days and in a few to 3000 r/air over 17 to 18 days using the same physical factors and the second and third course omitted.

Fig. 3—Pohle's technic for post-operative roentgen therapy. The figure illustrates the four fields used: (1) anterior chest wall, (2) anterior axilla, (3) anterior supraclavicular and cervical, and (4) posterior axilla.

Results

The five-year survival figures are given in tables 5 to 13 and figures 4 to 6. A total of 77 patients of the whole group of 198 (=39%) were known to have lived five years or more.

The best results were obtained in group I with 31 patients out of 38 alive five years. Thirteen patients were treated in 1946 and eight of these were alive ten years later (table 5). The results in group II were not so good with only 38 out of a total of 100 patients surviving five years. None of the 13 patients treated in 1946 lived ten years (table 6).

When all the operable cases were considered, the five-year survival was 50% (table 7). In this group there were several patients with locally advanced carcinoma. In 14 of these cases the data recorded in the charts indicated that they could have been classfiied as inoperable according to Haagensen's clinical criteria. Only one of these patients lived five years. This particular patient died from carcinomatous metastases six years after treatment (table 8). In group II there were 62 patients who were considered operable according to Haagensen's criteria and 28 of these were known to be alive five years or longer. Adding these 62 patients to the 38 patients in group I with cancer confined to the breast, we have a group of 100 patients

Table 5—Group I Survival Operable Cancer Limited to the Breast

	No.	Years									
		1	2	3	4	5	6	7	8	9	10
1946	13	13	12	10	9	9	9	8	8	8	8
1947	6	6	6	6	6	5	5	5	4	4	
1948	4	4	4	4	4	4	4	4	4		
1949	4	4	4	3	3	3	3	2			
1950	6	6	6	6	6	6	5				
1951	5	5	5	5	5	4					
No. surviving		38	37	34	33	31	26	19	16	12	8
Per cent		100	97	90	87	82	79	70	70	63	62

TABLE 6—GROUP II SURVIVAL OPERABLE CANCER WITH AXILLARY NODE METASTASES

	No.	Years									
		1	2	3	4	5	6	7	8	9	10
1946	13	11	7	2	2	0	0	0	0	0	0
1947	13	11	8	7	5	5	4	2	2	2	
1948	20	18	17	15	12	8	6	6	5		
1949	17	15	13	11	10	8	7	7			
1950	19	18	16	12	11	9	8				
1951	18	16	11	11	9	8					
No. surviving		89	72	58	49	38	25	15	7	2	0
Per cent		89	72	58	49	38	30	24	15	8	0

TABLE 7—SURVIVAL OF ALL OPERABLE CASES

	Total	Years After Treatment									
		1	2	3	4	5	6	7	8	9	10
1946	26	24	19	12	11	9	9	8	8	8	8
1947	19	17	14	13	11	10	9	7	6	6	
1948	24	22	21	19	16	12	10	10	9		
1949	21	19	17	14	13	11	10	9			
1950	25	24	22	18	17	15	13				
1951	23	21	16	16	14	12					
No. surviving		127	109	92	82	69	51	34	23	14	8
Percentage	100	92	79	67	59	50	44	38	33	31	31

TABLE 8—STAGE II CASES SURVIVAL

	No.	Alive 5 yrs. or longer	%
Operable According to Haagensen	62	28	45
Inoperable According to Haagensen	14	1	7
Indeterminable	24	9	38
Total	100	38	38

TABLE 9—GROUP I SURVIVAL WITH DIFFERENT COURSES OF IRRADIATION

Courses	I	II	III	Total
No. of cases	22	2	14	38
Alive 5 yrs.	16	2	13	31
Percentage	73	100	93	82
No. dead or living with cancer after 5 yrs.	2	0	1	3

TABLE 10—GROUP II SURVIVAL WITH DIFFERENT COURSES OF IRRADIATION

No. of courses	I	II	III	Not stated	Total
No. of cases treated	49	16	31	4	100
Dead within 5 years	30	8	21	3	62
Alive 5 years	19	8	10	1	38
Per cent alive	39	50	32	25	38
No. of cases living with cancer or dead after 5 years	6	2	4	0	12
No. of cases living well 5 to 10 years	13	6	6	1	26

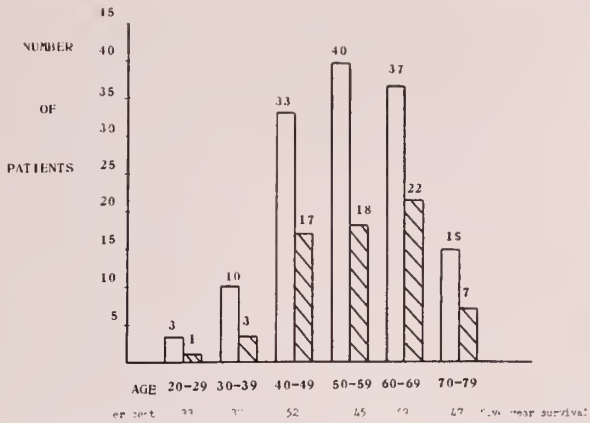

Fig. 4—Age distribution and five-year survival of operable cases. White stack indicates total number of patients in any one group. Slanted line stack indicates number of patients surviving five years in this particular group.

who fulfill all the clinical criteria of operability described by Haagensen. Fifty-nine of these patients survived five years and this figure is identical to the five-year survival rate reported by Haagensen[2(d)] and similar to that for the operable group (Stage I and II) reported by McWhirter.[3]

Considering next the five-year survival rates according to the age of the patient at the time of treatment, the best results were obtained in the 60 to 69-year group with 22 of 37 patients (59%) with operable cancer living more than five years (fig. 4).

The survival rates related to the duration of symptoms before treatment are given in figure 5. The best results were obtained in the group of 27 patients who had been treated within one month after noticing the first symptom with 19 patients surviving 5 years (70%). This is almost twice the survival rate recorded for the group of 22 patients who had noticed the first symptom from six to twelve months prior to treatment. Only 8 patients had had symptoms for more than one but less than two years. Five of them were alive at the end of two years. A selection of relatively slow growing tumors in patients presenting with tumors still operable after one year may explain this relatively high survival figure.

An attempt was made to correlate the dose of radiation with the five-year survival rates. In group I 16 patients out of 22 who received one course of x-ray therapy only survived five years (73%) while 13 patients out of 14 receiving three courses survived this length of time (table 9). Since the numbers are small definite conclusions cannot be

Table 11—Group III Survival Carcinoma of the Breast Having Incomplete Data Regarding the Histology of the Lesion or the Regional Node Contents. Surgery Performed at Hospitals Other than the University Hospitals

	No.	Years									
		1	2	3	4	5	6	7	8	9	10
1946	2	1	1	1	1	1	1	1	1	1	1
1947	4	4	3	2	1	1	1	1	1	1	
1948	1	1	1	0	0	0	0	0	0		
1949	3	3	2	2	2	2	2	2			
1950	1	1	1	1	1	1	1				
1951	2	1	0	0	0	0					
Total	13	11	8	6	5	5					
Percentage	100	85	61	46	38	38					

Table 12—Group IV Survival Inoperable Cases of Carcinoma of the Breast Treated for Palliation Only

	No.	Years									
		1	2	3	4	5	6	7	8	9	10
1946	7	2	1	1	1	1	0	0	0	0	0
1947	4	3	0	0	0	0	0	0	0		
1948	1	1	1	1	0	0	0				
1949	0										
1950	1	0	0	0	0	0					
1951	0										
Total	13	6	2	2	1	1					
Percentage		46	15	15	8	8					

Table 13—Group V Survival of All Recurrent Cases

	No.	Years									
		1	2	3	4	5	6	7	8	9	10
1946	2	2	2	1	1	0	0	0	0	0	0
1947	7	4	3	1	1	0					
1948	5	4	3	3	2	1	1	1	1		
1949	5	3	3	1	1	1	1	1			
1950	5	2	2	1	0	0	0				
1951	10	4	2	1	1	0					
Total	34	19	15	8	6	2					
Percentage		56	44	24	18	6					

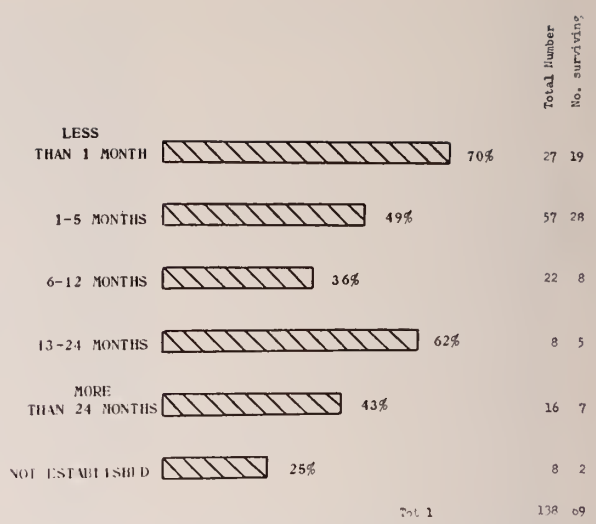

Fig. 5—Five-year survival of operable cases related to duration of symptoms.

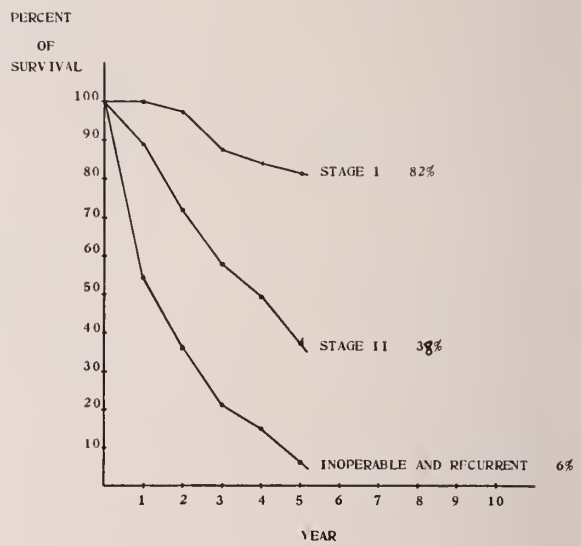

Fig. 6—Survival of different states of breast cancer.

drawn, but the data suggest that the higher dose gives better survival. A similar trend could not be demonstrated in group II cases (table 10).

It will also be noted that in this group of 138 operable cases 15 were known to have died or were living with cancer more than five years after treatment. This leaves only 53 patients who appeared to be living free of cancer from five to ten years after treatment.

In group III 5 out of 13 patients were known to be alive after five years. Only one of the 13 cases in group IV survived five years (table 12) and two out of 34 patients with recurrent breast cancer lived five years (group V) (table 13). The marked difference in survival rates in the various groups is illustrated in figure 6.

The survival figures do not illustrate the palliative effects of x-ray therapy of breast cancer. Nevertheless it is well known to most physicians that there is no other method which can offer better palliation in patients with bone metastases in terms of relief of pain, promptness of action and simplicity of administration. Approximately 70% of patients with osteolytic metastases report good pain relief and in about half of these objective radiographic evidence of recalcification and healing of the osteolytic foci can be demonstrated.[17] The dose need not be high

and the treatments can be given without side effects if lesions are relatively limited in extent. The radiosensitivity of local skin nodules is usually sufficient to result in complete disappearance after a few x-ray treatments with a total dose of 2000 to 3000 r/air over one to two weeks. Malignant pleural effusion may reaccumulate at a slower rate or become arrested for several months after external x-ray therapy or intrapleural injection of radioactive colloidal gold. Occasionally patients with brain metastases may experience temporary relief of headaches after a low dose of x-ray therapy.

Many of these patients with far advanced breast carcinoma present serious therapeutic problems. Judiciously administered radiotherapy frequently in conjunction with the newer chemotherapeutic agents may greatly aid in the management of these patients. Radiation castration in premenopausal women with metastatic breast cancer has not been shown to be inferior to surgical oophorectomy in inducing temporary clinical remissions. Recent advances have made radiations useful in suppressing the hormone production of the pituitary gland resulting in temporary palliation in far advanced breast cancer.

Complications

There were 18 patients in our series with recorded complications due to treatment (table 14). Ten of these had lymphedema of the arm, most likely unrelated to the radiotherapy (7.3% incidence). Stone and Vermund[10] reported an incidence of 6.7% lymphedema of the arm after radical mastectomy and postoperative radiotherapy. These figures are similar to those reported by Haagensen after radical mastectomy without postoperative radiotherapy.[2]

Pulmonary fibrosis was recorded in only 5 patients in our series, but this figure is probably too low since chest x-rays were not taken routinely after the roentgen therapy. Incapacitating symptoms related to the pulmonary fibrosis could not be demonstrated in any of these patients. In the material reported from Minnesota[10] 37 patients were found to have some degree of pulmonary fibrosis probably related to roentgen therapy —an incidence of 12%. Only a couple of patients had incapacitating symptoms referable to the fibrosis. In the majority the lung fibrosis was reported as an incidental finding on the chest film and was of no clinical significance.

TABLE 14—RECORDED COMPLICATIONS OF OPERABLE CASES

Edema of Arm	10
Radiation Fibrosis	
Transient	1
Permanent	4
Incapacitating	0
Severe Skin Damage	1
Rib Fracture with Osteitis	2

Rib fractures with osteitis was noted in two patients in our series. A change in the technic has allowed more even distribution of the x-ray dose to the chest wall. Severe skin damage was noted in one patient, necessitating a skin graft. Such complications can also be avoided by newer technics and higher energy radiation.

The main problem remains in the prevention and the control of distant metastases. More than 20% of all patients treated with radical mastectomy and postoperative radiotherapy developed bone metastases and a similar number developed metastases to the lungs, pleura or mediastinum.[10] Many of these patients undoubtedly had distant metastases at the time of the treatment, the detection of which still being impossible with present methods.

Summary and Conclusions

An analysis of the five-year survival rates in patients with breast cancer treated with radiotherapy from 1946 to 1951 has been presented. In 138 patients with histologically confirmed breast cancer the treatment consisted in radical mastectomy and postoperative roentgen therapy. Eighty-two per cent of patients with the cancer confined to the breast were alive more than five years. Thirty-eight per cent of patients with axillary node metastases survived five years. Fifty per cent of patients classified as operable lived more than five years.

Fourteen patients, considered inoperable according to Haagensen's clinical criteria, were treated with radical mastectomy and postoperative roentgen therapy. All of them except one died within five years and this lone survivor died from cancer six years after therapy.

One hundred patients were classified as operable according to Haagensen's clinical criteria. Fifty-nine of these survived five years.

A critical review of the role of radiotherapy in the treatment of breast cancer has been given.

Improvement in the results of treatment of carcinoma of the breast will most likely result from:

1. Earlier diagnosis and prompt radical treatment.
2. Carefully selected treatment for each individual patient through the combined evaluation of surgeons and radiotherapists familiar with the problems encountered in the therapy of breast cancer.
3. Improved technics and increased dosage of high energy radiation allowing homogeneous distribution to the anterior chest wall and the lymph draining areas in patients with residual carcinoma after radical mastectomy and in patients with locally advanced carcinoma.
4. Development of cancerostatic chemotherapeutic agents to be used in patients with distant metastases.

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Treatment of Nodular Toxic Goiter With I^{131}*

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THE RESULTS OF radioactive iodine treatment of diffuse toxic goiter are well recognized, but less data are available concerning its effects in nodular goiter. Previous reports[1-5] have emphasized that patients with nodular toxic goiter require larger quantities of I^{131} and a longer time to achieve a remission than do patients with diffuse goiter. Further, the incidence of hypothyroidism following radioiodine therapy is reported to be lower in this group. In view of these findings additional observations on the results of radioiodine treatment of nodular toxic goiter are of interest.

The purpose of this paper is to present data on 155 patients with nodular toxic goiter treated with I^{131} between 1947 and 1955, and adequately followed. Data from 313 patients with diffuse goiter similarly treated are available for comparison.

Clinical Material and Methods

Evaluation of Patients: The diagnosis of nodular toxic goiter was established in each case by complete history, physical examination, and determination of 24-hour radioiodine uptake. Basal metabolic rate and serum protein-bound iodine determinations were done when indicated for further diagnostic clarification. Serum cholesterol levels were measured for reference comparison with post-therapy values.

The diagnostic criteria for nodular goiter deserve some definition. Patients were included in this series if the thyroid felt nodular to the examiner. Approximately 87% of the patients presented multinodular goiters and 13% had glands with single nodules. Histologic examination of biopsy specimens was not done so that differentiation between true toxic adenoma and diffuse toxic goiter with adenomatous change was impossible.

The age distribution of the patients in this series is shown in table 1. A number of young patients have been included, since facilities were available for careful, prolonged follow-up observations, required in an experimental group. Prior therapy, given elsewhere, varied widely and is summarized in table 2. It is evident that about two-thirds of the cases represented recurrences of thyrotoxicosis following conventional therapy.

TABLE 1—AGE DISTRIBUTION OF PATIENTS WITH NODULAR TOXIC GOITER

Under 36 Years	22
36 to 55 Years	70
Over 55 Years	63
	155

TABLE 2—PRIOR THERAPY RECEIVED BY PATIENTS WITH NODULAR TOXIC GOITER

Thyroidectomy	43
Propylthiouracil (PTU)	18
Iodide (I)	15
PTU and I	25
Roentgen irradiation	4
None	50
	155

Plan of Treatment: Radioiodine dosage in each case was calculated on the basis of a desired tissue concentration of 50 to 100 microcuries per gram of thyroid, the estimated weight of the thyroid and the 24-hour uptake of the test dose. Most frequently 75 microcuries per gram was used as the tissue concentration of the isotope. Following initial therapy patients were evaluated at 3-month intervals and additional radioiodine given as necessary until a remission was achieved.

Follow-up: Since September 1956 follow-up observations have been made after the last dose of I^{131} was received. The duration of this

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Presented at Midwest Regional Meeting, American College of Physicians, September 27, 1958, Milwaukee, Wisconsin.

Table 3—I^{131} Required for Remission

	Nodular	Diffuse
Under 4 mc.	22%	30%
4.1 to 10 mc.	57%	56%
10.1 to 15 mc.	15%	8%
Over 15 mc.	6%	6%

Table 4—Remission Time

	Nodular	Diffuse
By 3 months	57.4%	62.0%
By 6 months	17.6%	16.6%
By 12th month	12.0%	14.0%
Over 12 months	13.0%	7.4%

Table 5—Reduction in Thyroid Size

	Nodular	Diffuse
To Normal	58.6%	93.5%
No Change	10.7%	1.8%
Intermediate Decrease	30.7%	4.7%

follow-up period was less than 6 months in only two cases, from 6 months to 6 years in 97 cases, and from 6 to 10 years in 56 cases.

Results of Therapy

The results of radioiodine therapy in this group of patients have been assessed in several ways.

I^{131} Requirements: Although the maximum total dose employed (70 mc.) exceeded that required in diffuse goiter, the average total dose was 8.1 mc. This is not significantly different statistically from the requirement in diffuse goiter (7.1 mc.). The distribution of patients according to the amount of I^{131} required is shown in table 3. Over one-half were controlled with a total dose between 4.1 and 10 mc., 22% needed 4 mc. or less, 15% needed 10 to 15 mc. and 6% required over 15 mc. Comparison with the diffuse goiter patients revealed that in the diffuse goiter group a significantly higher percentage (30%) was controlled with 4 mc. or less, and a significantly lower percentage (8%) required 10.1 to 15 mc. These differences, though statistically significant, are not striking.

Remission Time: The time required to induce a remission is shown in table 4. Over half were in remission when seen at the first follow-up visit 3 months after treatment. No significant prolongation of remission was observed in the nodular cases when compared with the patients with diffuse goiter.

Response to Therapy: Fifty-four per cent of the cases were euthyroid at 3 months; this is considered to be an excellent result. Twenty-eight per cent were euthyroid within 6 to 12 months; this is classed as a good result. In 13% more than 12 months were needed to achieve a remission. Although euthyroidism was attained, the prolonged remission time is undesirable and this is classed as a poor result.

Hypothyroidism: The incidence of permanent hypothyroidism in this series was 5.3%, slightly but not significantly lower than the 8.9% observed with the diffuse goiter group. Development of hypothyroidism was not correlated with an exceptionally large dosage of I^{131} since the mean dose in these 8 patients was 5.8 mc. The time of onset of permanent hypothyroidism after completion of radioiodine therapy is of interest. In 7 patients this occurred within 1 to 2 years, while in one patient it did not appear until after 3 years.

Decrease in Thyroid Size: As shown in table 5 significantly less favorable results were obtained in reduction of thyroid size. This is not an unexpected finding, although the results in this regard are still reasonably satisfactory.

Exophthalmos: In two-thirds of the patients in whom exophthalmos was present before I^{131} this manifestation regressed to normal after therapy. No instance of progressive exophthalmos was encountered after treatment in this group.

Recurrence: The incidence of recurrence of thyrotoxicosis after 12 months of euthyroidism has been 3.1%, compared with 0.6% in patients with diffuse goiter. All recurrences were successfully treated with additional radioiodine.

No instances of neoplasm neglected by this form of therapy have been encountered during the follow-up period.

Discussion

The use of radioactive iodine for the definitive therapy of nodular toxic goiter has been opposed by many well informed clinicians because of the possible objections previously listed: the need for larger doses to attain euthyroid status for the patient, slower appearance of the clinical remission, and vague

uneasiness concerning the possible undetected co-existence of neoplasm, or its later development in nodular thyroid enlargement. The results reported in this study appear to eliminate most of these objections since any differences in total isotope dosage or in remission time are very small and statistically insignificant. The problem of unrecognized neoplasm remains, but in toxic nodules this danger is known to be extremely small and of little importance. A greater theoretical danger may concern the co-existence of "hot" and "cold" nodules in the same gland, with neoplasia present in the latter. It is probable that improved isotope instrumentation with more highly collimated counting will permit more accurate identification of this situation when it exists, the treatment for which should then obviously be surgical thyroidectomy. Since the problem of neoplasm was not encountered in the present series of cases, the authors believe that its incidence, if present, must be exceedingly small.

Question may arise whether the favorable results with nodular toxic goiter reported here are not due simply to the inclusion of a large proportion of cases of diffuse toxic goiter with adenomatous change, with a smaller number of cases of true toxic adenoma, said to respond less favorably to radioiodine. It should be emphasized that in neither the present cases nor in a previous series,[5] in which the results are at variance with ours, have histologic examinations of the thyroid been made. Whether there is, in fact, a real difference in behavior of these two types of nodular goiter in reference to the use of radioiodine must remain unsettled until a biopsy controlled series is reported.

On the basis of the present information radioiodine may be considered a very satisfactory form of therapy for nodular toxic goiter.

Summary

These data suggest that nodular toxic goiter responds satisfactorily to radioactive iodine therapy. Comparison of results with these obtained in diffuse toxic goiter reveals that I^{131} requirements are not significantly greater, remission time is not prolonged, the response in terms of control of the disease is comparable and frequency of hypothyroidism is similar. As might be anticipated, reduction of thyroid size to normal is significantly less common. In conclusion, I^{131} may be considered an effective form of therapy in cases of nodular toxic goiter.

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COMMENTS ON TREATMENT

The Use of Medicinal Iron in Pediatric Patients

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DURING THE PAST quarter of a century significant advances have been made in our knowledge of iron metabolism. Likewise, significant improvements have been achieved in therapeutic iron preparations that are available to physicians. During this same period medical care has become available to all, and our economic and educational endowment has never been greater. In spite of these scientific, social and economic advances, the present day incidence of iron deficiency anemia in early life remains as high in the United States as it was during the depression years in the early 1930's. Thus, the physician must continually be aware of the indications for the use of medicinal iron in early life and must appreciate how this medication is used effectively.

Experiments in which the absorption of iron from the diet of infants and young children has been determined quantitatively have demonstrated that "normal" diet *can* satisfy the iron requirements of modern day, rapidly growing infants.[1] Even with such normal dietary intakes of iron there is very little iron available in excess of the basic requirements for growth in most infants. Thus, any situation which increases the demand for iron such as blood loss, gastrointestinal disease, or an unusually rapid growth rate becomes an indication for supplementing the dietary intake of iron with some medicinal form of iron.

Theoretically medicinal iron should only be administered for the prevention of frank iron deficiency anemia. If the physician were ever alert to the clinical states which increase the demand for iron, and if patients consulted their physician frequently, this would perhaps be possible. Being able to restrict the use of medicinal iron to its preventive role is a goal we should strive for, particularly in pediatric practice where the rewards of preventive practices are so great.

Indications for the administration of iron in pediatric patients are listed in table 1. Growth rates and dietary intakes of iron differ markedly at various ages and thus there are certain differences in the clinical situations one will encounter in the different age groups which demand iron administration. These indications have been discussed in more detail elsewhere.[2]

TABLE 1—INDICATIONS FOR THE ADMINISTRATION OF IRON

I. 0 to 4 Months of Age
- A. Prematurity
- B. Multiple births
- C. Blood loss (before, during, or after birth)
- D. Infants of iron-deficient mothers

II. 4 to 36 Months of Age
- A. Iron deficiency anemia
- B. Blood loss, including surgery
- C. Inadequate diet
- D. Malabsorption syndrome
- E. Unusual rapid growth

III. 3 to 10 Years of Age
- A. Blood loss
- B. Malabsorption syndrome

IV. 10 to 18 Years of Age
- A. Blood loss, including menorrhagia
- B. Unusual rapid growth
- C. Malabsorption syndrome

Certain facts concerning the metabolism of iron salts are now well established and become important considerations in the therapeutic use of iron. Ferrous iron salts are assimilated more efficiently from the gut than are ferric salts of iron. A variety of food substances, particularly phosphates, inhibit the absorption of iron. Iron is absorbed more readily in iron deficient subjects than in normal or hemosiderotic individuals. There is no normal mechanism by which iron can be excreted from the body once it is absorbed or

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administered parenterally. The so-called "mucosal-block" to iron absorption operating in the intestinal mucosa in normal or iron loaded individuals to prevent further iron absorption is ineffective and is no longer felt by most workers to be present.[1] Even hemosiderotic individuals will continue to actively assimilate orally administered iron, and the prolonged administration of iron to non-iron deficient persons has resulted in fatal hemochromatosis.

The Physicians' Desk Reference lists 170 preparations as useful in the prevention and treatment of iron deficiency anemias. None is more effective than simple ferrous salts, most are more expensive and many are more dangerous.

Either ferrous sulfate or ferrous gluconate are suitable ferrous salts readily available in concentrated drop form for administration to infants or in tablet form for use in older children. It is rare indeed to encounter gastrointestinal intolerance to these preparations in this age group.

Molybdenum added to iron preparations (Mol-Iron) has not been shown to enhance the effectiveness of the iron medication. Cobalt in combination with iron (Roncovite) does not increase the effectiveness of the iron, and is dangerous in that it has a toxic goitrogenic effect particularly when given to young infants or to pregnant women.[3]

The recommended therapeutic practice in the first three years is to use simple drop doses of ferrous salts, administering a daily dose of 60 to 75 mg. of elemental iron in two to three divided doses "away" from food.

In older children tablets of ferrous sulfate (0.2 gm.) or ferrous gluconate (0.3 gm.) will be more suitable. One or two of these tablets taken at meal time will provide 220 to 440 mg. of iron daily.

It is regretable that all too often parents and physicians alike have a poorly controlled enthusiasm for injectable forms of medication. Recently iron-dextran for intramuscular administration has become available. The following facts should be kept in mind to temper the injudicious use of this material.

1. Only a rare patient with iron deficiency anemia fails to tolerate and respond satisfactorily to iron salts given by mouth.
2. Toxic reactions following parenterally administered iron do occur and may occasionally be severe.
3. The body has no normal mechanics for the excretion of iron. Indiscriminate use of parenterally administered iron may produce toxic iron-overload.
4. There is no increase in the rate of hemoglobin production in patients treated with parenteral iron when compared to those treated with oral iron.[4]
5. This form of iron medication may involve unnecessary expense and discomfort to the patient.

The hemoglobin response to iron medication in the anemic subject is delayed 5 to 7 days after initiation of therapy and then proceeds at a rate of approximately 0.15 to 0.20 gm.% daily or roughly 1.0 gm.% per week. Failure of a patient with iron deficiency anemia to respond to iron therapy will be due to one of the following reasons:

1. Erroneous diagnosis
2. Inadequate amounts of iron prescribed
3. Failure of patient to take the medication
4. Administration of iron with large amounts of phosphorus-containing food (milk).

In the treatment of iron deficiency anemia it is of importance to realize that iron is preferentially used for hemoglobin synthesis.[5] Likewise, it is known that iron is assimilated in smaller amounts once the anemia is corrected. It is thus pertinent that iron medication be prescribed for 6 to 8 weeks after the hemoglobin has reached normal levels if iron stores are to be replenished. When iron is prescribed to prevent iron deficiency, a period of no less than 8 to 12 weeks of iron supplementation is indicated.

1300 University Avenue (6).

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The President's Page . . .

The New AMA

A new model American Medical Association is now on display before the physicians and the public. If you will pardon the analogy, since this is the month of the new auto showings, the new model AMA appears to offer a wider breadth of interest, a longer look ahead, and a dramatic change of styling. There seems to be new power "under the hood."

Part of the change, no doubt, comes as the result of new management. A rather sweeping reorganization has been taking place since the creation of a new position of Executive Vice President which has been filled by an astute Texan, Dr. F. J. L. Blasingame.

Another reason for the change is the new outlook of the Board of Trustees and the House of Delegates, particularly on matters of medical care plans, public health legislation and medical service.

I can personally testify to the feeling of change that is coming over the American Medical Association. In September it was my privilege to join with about 25 other physicians, scientists and educators at Hershey, Pennsylvania, to begin a thorough review of the AMA's scientific activities. This was a most revealing and stimulating experience. I am certain that it will lead to historic changes in the AMA's postgraduate medical education programs.

This is only one of many new approaches being made by the AMA to problems of public health, medical education and medical service. The meetings being held this month and next serve to show the trend.

President-Elect Doctor Sorenson and I have just returned from a two-day legislative conference in St. Louis. Officials from every State Medical Society in the Union were present. The AMA is really coming to grips with the threats of bureaucratic, socialistic philosophies being espoused for health care.

Better living for the aging was the subject of the AMA's six-state conference at Minneapolis on October 14–15. There is hardly a more explosive subject in the socio-political scene today. Medicine has important responsibilities to fulfill.

There was an AMA conference on Physicians and Schools at Highland Park, Illinois, October 13–14. Next is the conference for Medical Journals in Chicago, October 26–27; then a meeting on medical prepayment plans in Minneapolis on November 20–21, followed immediately by the North Central Medical Conference in the same city on November 21–22. There is an AMA Conference on Civil Defense in Chicago on November 7–8, and, of course, an important interim session of the AMA in Dallas, Texas, on December 1–3.

All of this represents a significant change in attitude by the AMA to meet the challenges of changing times. It was interesting to me to learn that about 50 per cent of AMA's budget goes into scientific activity, only about three per cent for the operation of the Washington office and legislative activity. Most significantly, an increasing percentage of the remainder is going into a determined effort to develop the social consciousness of the Doctor of Medicine as befits his place in a changing world. The bedside manner is still important, but only by developing a keen sense of public health responsibility and citizen awareness will the physician of the future play his traditional role in community leadership.

William B. Weldstrand M.D.

Editorial Director
DAVID N. GOLDSTEIN, M. D.

EDITORIALS

Two physicians have accepted the invitation of the WISCONSIN MEDICAL JOURNAL to discuss the pros and cons of compulsory social security for the medical profession. Their views are presented here.

Dr. Robert H. Lehner, of Racine, has convinced the majority of his own component group, the Racine County Medical Society, that physicians should abandon their lonely and perhaps tenuous perch on a unique pinnacle of the American social order.

On the contrary, Dr. Edgar End, of Wauwatosa, the Secretary of The Medical Society of Milwaukee County, has long been an active opponent of the Social Security concept. He has engaged in extensive investigation of social security during the past few years and presents herewith many interesting revelations worthy of careful reflection.

The facts and opinions which follow are those of the authors, and do not necessarily represent the viewpoint of the Editors of the WISCONSIN MEDICAL JOURNAL or the official policy of the State Medical Society of Wisconsin.

Readers of the WISCONSIN MEDICAL JOURNAL are cordially invited to state their views in letters to the Editor.

What Can Social Security Do For You?

To say we should have Social Security because the lawyers, dentists and others do, in itself has no more merit than when the opponents reason that it is no good because it is a form of socialization and against the traditions and self-sufficiency of the medical profession. One should analyze the economic possibilities of Social Security in relation to himself and fellow physicians.

Your Estate

For a physician and many others to build an estate and security for his family, it is necessary (1) to have substantial earnings, (2) to save some of this income, and (3) to conserve the savings by prudent investments. Many of us fall down somewhere along the line. Some never have large earnings, and remember that after subtracting your office and other expenses and paying your income taxes, over half of your gross income is gone. Some, not quite realizing this, live beyond their means or "going broke on $45,000 a year." Others save but because of their investments they do not have a substantial estate; maybe the oil well was a dry hole, the gold mine petered out, the uranium stock collapsed, or their farming activities weren't profitable. Social Security is a means of aiding the less fortunate.

Keogh Legislation

The Keogh bill and other similar legislation appeals to most of us. It gives us a chance to save a portion of our income without paying the income tax until a later date when these savings are needed. This will be a great aid to the self-employed in building an estate and security. But this will not be of much help to the young physician. He will not be able to accumulate enough in the early years for a real catastrophe. Social Security for his dependents will help bridge this gap.

Social Security Benefits

Social Security provides (1) survivor benefits, (2) retirement benefits, and (3) disability benefits. These benefits could be an important aid to you and your dependents. Most important to the young physician who has not had an opportunity to build up an adequate estate would be the survivor benefits. If he died, with full Social Security coverage, at the age of 35 and left a widow with a one-year and a three-year-old child, they would receive $232.00 per month until the oldest child is 18 years old, and then $174.00 per month until the youngest child reaches 18.

$58,000 Plus

What would this amount to for Dr. Thirty Five's dependents and widow? By the time the youngest child reached 18, it would be about $45,936.00, but when the widow reaches age 62, she would receive $87.00 per month; and if she lived another 12 years, this would amount to an additional $12,428.00, for a grand total of $58,364.00.

Disability Benefits

If Dr. Fifty became permanently and totally disabled at the age of 50, and if fully covered by Social Security, he could receive $116.00 monthly, after an initial waiting period of 6 months. If he had a wife and dependent child, under 18 or disabled, the payments could be as much as $232.00 monthly. At age *62* his wife could receive an additional $47.00 monthly. If Dr. Fifty had a dependent child until age *58*, and he and his wife survived to age *75*, the total amount paid them would exceed $52,000.00. Did you say these examples are extreme and unusual circumstances? Granted! But no more so than what is required for your dependents to collect your life insurance.

(continued)

Retirement Benefits of $20,000

Dr. and Mrs. Sixty-Five would be eligible for $174.00 monthly benefits, if the doctor ceases to earn more than $1,200.00 a year. Income from investments would be excluded in determining these yearly earnings. In 10 years these payments would amount to $20,880.00. Most of us, even if wealthy, would probably not retire at 65, if able to work. But is there not some physician in your acquaintance, unable to continue to practice at 65, who would have benefited? At age 72 you would be eligible, even if you continued to earn more than the $1,200.00 yearly maximum. And all this coverage for an annual cost of $180.00, at present rates.

Costs Too Much?

Although it is difficult to compare Social Security with life insurance, the comparisons I have seen greatly favor Social Security. And you would be eligible without a physical examination. The present cost to the self-employed person is 3¾% on the first $4,800.00 of income, or about two-thirds of the 5% paid for your employees; 2½% you contribute and 2½% is withheld from their salaries. Thus the self-employed person would pay $180.00 per year. This is not deductible from your income tax, but neither are your life insurance premiums. Will the Social Security Tax increase? Yes, there is a schedule of gradual increases projected to past 1969, ranging up to 6¾%.

The Polls

A recent poll of Racine County physicians favored Social Security two to one. Our county society sponsored a resolution to the last House of Delegates meeting, favoring a poll of all Wisconsin physicians; this resolution was adopted. Most of the statewide polls of other states have greatly favored Social Security. Why haven't we as physicians taken advantage of it?—ROBERT H. LEHNER, M.D.

Tell Ya What I'm A'Gonna Do . . .

Suppose a flashy character walked into your office and said, "Doc, I've got just the investment you've been waiting for. You won't get any certificate to show that you own it and you'll have to keep paying on it every year or you'll go to jail. This year it'll only cost you about five hundred iron men, but we'll see that you get a price rise regularly; and there's no limit to how high it can go. You'll have to retire at 65 to get anything out of it, but the majority of doctors don't quit that young, so you'll probably only get $250 to bury you instead of the thousands that you paid in. Don't let that discourage you, though, old man, because the owners have been dipping into the till and the whole darn thing's liable to go bankrupt unless you stockholders bail it out. It's a mutual company, you know."

Don't throw the fellow out! He isn't crazy and he isn't a crook. He's just an unusually honest salesman trying to sell you Social Security. If you don't interrupt him, he may tell you that the boss of Social Security, Administrator Charles Schottland, is an honest man, too, and in 1958 told interviewers that SOCIAL SECURITY IS A TAX AND NOT AN INSURANCE CONTRIBUTION, as the guardians of the Welfare State would prefer to have you believe. If you listen carefully, you may learn that:

1. Most MDs don't quit practice at 65; and the best they can expect to get for their thousands in Social Security Taxes is a $250 burial fund.
2. Social Security is government competition against private enterprise.
3. No participant has any vested rights or contract to protect him; and the whole set-up can be changed at the whim of Congress.
4. Legalized in 1939 as an emergency relief measure, all attempts at keeping the program on a sound actuarial basis have been abandoned; payment of premiums into a reserve fund has been discontinued; and the program is now in the hands of Social Planners who use it to replace individual initiative with abject dependence on the state.
5. The Act has been amended many times, without concern for the participants, and the tax will continue to be raised by Congress.
6. Benefits have never been raised on a sound actuarial basis but have come from vote-hungry Congressmen under pressure from labor unions and social planners.
7. In 1954 the House Ways and Means Committee revealed that:
   (a) There was not enough in the trust fund, even at that time, to pay future benefits;
   (b) In 1952 the average benefits equalled $24 for each 50¢ paid in; and *in 1954 Social Security was paying out $30 for every 50¢ collected in taxes;*
   (c) Total benefits to some individuals amounted to several hundred times the amount paid in.
8. Today Social Security is speeding toward bankruptcy by paying out MORE THAN 60 TIMES AS MUCH AS IT IS TAKING IN!

(continued)

9. At the present rate, each doctor would pay about $500 a year in additional taxes; and this amount will certainly be increased.
10. In event of a doctor's death, his wife would receive benefits only if she were 62 years old and earning less than $100 per month, or if she were less than 62 and had dependent children under 18 years of age and an annual earned income of less than $1,200. All payments would stop if she remarried or the youngest child reached 18. No legitimate insurance policy would contain such limitations.
11. Most young physicians would be better off financially buying insurance from regular insurance companies.
12. The Social Security Administration would have you believe that your payments are held in trust to pay future benefits. THIS IS NOT TRUE! In May, 1957, the unfunded obligation of Social Security was $300,000,000,000 (300 billion dollars) WHILE THE NATIONAL DEBT WAS ONLY $270,000,000,000! OF THIS STAGGERING SUM, THERE WAS LESS THAN ONE-FOURTH of 1% (about 22½¢ per $100) IN THE SO-CALLED "TRUST FUND"! Unknown to the participants, MORE THAN 99.75% of their contributions had been spent by the government for foreign relief handouts, socialistic relief programs, and other government boondoggling and had been replaced by treasury notes and certificates. When it comes time to redeem these IOUs, we and our children will be taxed again and again to pay back money that was originally taken from us as taxes.
13. If the medical profession accepts Social Security, you will participate or your property will be seized for non-payment of taxes; and you may even be sent to jail. You will have no choice. THIS IS VOLUNTARY SLAVERY!
14. Participation by the medical profession will deliver us as a group into the hands of the government planners who have sworn to bring socialized medicine to this great nation whose strength lies in the ability of its citizens to provide for themselves.
15. The argument that "the legal profession has accepted Social Security" is invalid because this acceptance came about as the result of a parliamentary trick engineered by a small group and did not represent the desires of the majority (who are now heartily discouraged with the whole thing).
16. If we accept Social Security, it will kill any chance for real retirement legislation such as the Simpson–Keogh Bill under which, INSTEAD OF PAYING MORE TAXES, we could defer the tax on a substantial part of our income if it were put into a retirement investment.
17. Finally, as a group, let us shun any "hurry up and get on the gravy train" appeals to greed and thus show the world that there still exists one profession in which decent men ask, "What can I do to serve my country?" and not, "What can I get out of it?"—EDGAR END, M.D.

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Diggings Bring Back Memories of old "Madison Sanitariam"

SECTION ON MEDICAL HISTORY

Just a couple of hundred yards northwest of the State Medical Society headquarters excavations are in progress. The plan is to construct an apartment building on the shores of Lake Monona.

Diggings have turned up some old sidewalks and the memory of the old "Madison Sanitariam" which occupied the site some 30 years ago.

According to Dr. William T. Lindsay, Madison, the sanitarium was built in 1898–1899. It was a project of the Wisconsin Conference of Seventh Day Adventists. The hospital section was headed by Dr. C. P. Farnsworth and it was noted for its hydrolic therapy (hydrotherapy) and massage treatments.

—Photo courtesy Dr. W. T. Lindsay

Shown in the picture above is the "Madison Sanitariam" at the right. The nurses' quarters were in the building at the left. In the center is the "summer kitchen," or patio, as it is now called. The picture was taken at the turn of the century, 60 years ago.

Doctor Lindsay recalls that the hospital had a good nurses' training program, and at least one of the nurses, a Miss Ann Janke, is still employed at Madison General Hospital.

A description of the institution runs as follows: "The sanitarium was an imposing three-story structure of frame, ample in size, with roomy verandas running around three sides. It was well patronized in its heyday. Its management purchased a steamboat which made four regular trips daily to and from the city shore."

Doctor Lindsay joined the staff in 1905 as an intern. He stayed until 1907 when he went to another Seventh Day Adventist hospital in Chamberlain, South Dakota. It was Doctor Farnsworth, also a prime mover in the Chamberlain hospital, who asked Doctor Lindsay to manage it.

In 1912, Doctor Lindsay returned to Madison to become superintendent of the sanitarium. His wife gave the anesthesia at the institution.

About 1918 trouble brewed. The hospital's operating board and the medical advisor insisted that Doctor Lindsay become their employee. This he would not do.

According to him, the idea of hospitals taking over the practice of medicine was not new. In fact, there was a Doctor Holden in Portland, superintendent of another Seventh Day Adventist hospital, who also held out against being employed by such hospitals. Doctor Lindsay left the institution in 1920.

Following his departure the hospital had a stormy history. A Doctor Engersoll purchased the hospital but lost it. A Mrs. L. P. Larson tried to manage the hospital. Finally, it went to the Bank of Madison because it could not meet its financial obligations. In 1922, the sanitarium closed its doors.

The history of the State Medical Society site is certainly unique: as far back as a century it has harbored some aspect of medicine. In 1855 the Lakeside Water Cure was erected just to the east. It burned down after a couple of shaky years. Then came the Madison Sanitariam. Finally, in 1955, the permanent headquarters of the medical profession of Wisconsin was raised.

THE MEDICAL FORUM

STATE AFFAIRS

LEGISLATION

Bills Up For November

When the state legislature reconvenes on November 3rd one of the most important issues will be the question of finance.

All the figures are not in yet. The November session will add more costs to state government. And the best guess is that at the end of the biennium there will be a deficit of some $27 million. To wipe this out, new taxes will have to come from "somewhere".

A brief summary of the bills which were held over until the November session:

Public Welfare

Bill 830, A. would liberalize provision limiting number of patients to be admitted to Wisconsin General hospital at joint county-state expense. The law now states that persons admitted from counties where there is a hospital must be maintained entirely at county expense. The bill would continue to require this only if there were a hospital in the county having 30 or more beds.

Bill 430, A. would set up a governor's commission on alcoholism to study all phases of prevention, treatment and rehabilitation. Annual cost: $40,000 with the money being deducted from the occupational tax on intoxicating liquors before the tax was shared with local governments.

Regulatory Measures

Bill 423, A. requires persons offering psychological services to be certified and licensed by a state board of examiners. A $20 annual fee would be charged to each registered psychologist. SMS is opposed.

Bill 244, S. would create a state optician's examining board which would supervise the examination of opticians and require annual registration. Bill prohibits practicing without registration and advertising prices of lenses, glasses, frames or fittings. SMS favors if, instead, registrations was placed under State Board of Medical Examiners.

APPOINTMENTS

Commission on State Depts.

During a recent meeting the following physicians were appointed or reappointed to Divisions of the Commission on State Departments. All terms end in 1962.

Division on Handicapped Children: Dr. D. W. McCormick, Fond du Lac (reappointment); Dr. George H. Handy, Wisconsin Rapids.

Division on Aging: Dr. Craig Larson, Milwaukee; Dr. B. F. Eckardt, Sheboygan, (both reappointments).

Division on Maternal and Child Welfare: Dr. E. A. Birge, Milwau-

"A chiropractor cannot do the following . . ."

Early this month the State Board of Medical Examiners put all licensed chiropractors in Wisconsin on notice regarding the limits of their techniques by sending each the following letter:

Dear Sir:

Most of the uncertainties regarding the limits of chiropractic have now been resolved by the decision of the Wisconsin Supreme Court in State vs. Grayson, 5 Wis. (2d) 203.

It is the responsibility of the Wisconsin State Board of Medical Examiners to enforce the provisions of Chapter 147 of the Wisconsin Statutes and acting under the direction of the Board, I am sending this letter to all licensed chiropractors in the State of Wisconsin.

The Grayson case makes it clear that a chiropractor cannot do the following which are illustrative only and not meant to be all inclusive:

1. Use the title "Doctor" or any initials indicating he is a doctor including the initials "D. C.".
2. Take or use blood samples of patients.
3. Prescribe, suggest or advise a course of diet and corrective dietary habits.
4. Prescribe, suggest, advise and dispense food supplements and vitamins.
5. Render psychosomatic counseling to his patients.
6. Use the following instruments:
   (a) Colonic irrigators
   (b) Diathermy
   (c) Plasmatic
   (d) Short Wave
   (e) Radionics
   (f) Ultra-sonic

If any licensed chiropractors are using any of the above mentioned modalities, machines or methods or treatment, this is a formal notice to them to cease and desist immediately.

Any violations noticed or called to the attention of the Wisconsin State Board of Medical Examiners will be prosecuted.

Yours very truly,
(signed) THOS. W. TORMEY, JR., M. D.
Secretary

kee; Dr. K. J. Winters, Wauwatosa, (both reappointments); Dr. Stewart L. Griggs, Green Bay.

Division on Nervous and Mental Diseases: Dr. E. M. Burns, Madison; Dr. Keith Keane, Appleton (both reappointments); Dr. Francis M. Forster, Madison; Dr. Owen Otto, Milwaukee.

Division on Public Assistance: Dr. C. M. Carney, Beloit; Dr. E. W. Schacht, Racine (both reappointments).

Division on Safe Transportation: Dr. Marvin Wright, Rhinelander (reappointment); Dr. Richard C. Wixson, Madison; Dr. Richard B. Windsor, Sheboygan.

Division on School Health: Dr. John G. Heisel, Superior (reappointment); Dr. John W. Harkness, Wauwatosa.

Division on Chest Diseases: Dr. Einar R. Daniels, Milwaukee; Dr. Thorolf E. Gundersen, La Crosse; Dr. Warren K. Simmons, Rhinelander (all reappointments).

The Commission also decided that if a division member becomes chairman of that division by appointment of the Council, he must resign his membership, appointing someone in his place to maintain his division at full strength.

SPECIAL INHALATION THERAPY institute, sponsored by the SMS Foundation in September, was held in Wausau. Dr. E. R. Levine (left) director of inhalation therapy at Edgewater Hospital, Chicago, demonstrates new oxygen equipment to Dr. John Rankin, University of Wisconsin School of Medicine and Sister Mary Kathleen, administrator of local St. Mary's Hospital. Over 200 attended the Clinic.

POLITICS

Presidential Candidate

In 1960 the U. S. voter will once again be treated to that strange, humorous, vibrant—and vital—spectacle known as the presidential campaign.

For months now candidates for that highest office in the world have been hustling to the precincts of Wisconsin in hopes that its spring primaries will show others the light.

Recently Sen. **Hubert H. Humphrey**, Minnesota, paid Madison such a call. Because federal legislation is increasingly threatening free medicine, a *Medical Forum* staffer attended a press interview.

Question: What was Sen. Humphrey's stand on Forand type legislation, (federal health insurance for those under social security)?

Reply: "I am for federal hospitalization and nursing home care, but I would leave the free choice of physician to the patient."

Question: Would he advocate any type of federal health insurance for those below 65 or for any specific group below 65 such as the migrant workers?

Reply: "No. I disagreed with certain features of the Forand Bill. Instead I introduced legislation for federal hospitalization insurance for those covered by social security, but my bill permitted the free choice of physician in instances of medical and surgical care."

Then the *Medical Forum* double-checked with the AMA's legal division. Here is their reply:

"It is true, in a manner of speaking, that by not including provisions for surgical care Senator Humphrey has provided for free choice of physician. The same, however, could be said of the Forand Bill with respect to physicians other than surgeons.

"Since both the Forand bill and the Humphrey bill provide for 'staff services,' presumably the social security beneficiary would receive medical and other services provided by staff physicians to any patient. With the above comments in mind, Senator Humphrey's bill does follow the line he indicated in answers to your questions.

"Probably the greatest danger, other than the obvious control of hospitals which the Federal Government would have, would be that this legislation would be merely the camel's nose coming through the tent flap. Obviously, there would be great pressure to provide beneficiaries both surgical and medical care by physicians.

"This bill, then, is different from the Forand bill only in the matter of degree. It is objectionable for the same reasons that the Forand bill is."

* * *

In fairness to Senator Humphrey, the *Medical Forum* will endeavor to ask precisely the same questions—and do the same double-check—to all candidates who visit Wisconsin. The physician has a right to know.

STATE AFFAIRS

SPECIAL HONORS went this summer to Dr. Charles Giesen (left) and Dr. Victor Ekblad, both of Superior, at a dinner given by the local Sisters of St. Mary's Hospital. The occasion was the 80th birthday of Dr. Giesen and the golden anniversary of Dr. Ekblad's practice in Superior. Members of Douglas County Medical Society, their wives and staff physicians from Duluth attended the festivities.

AUXILIARY

Rock County Offer

Rock County Medical Auxiliary has taken on a foreign students' project for the next year.

Physicians' families will invite foreign students at Beloit and Milton colleges into their homes for holidays and an occasional weekend.

TRAFFIC SAFETY

The Cost of Accidents

Recently Racine drew high praise of the National Safety Council for having ranked 14th of 125 cities in the 1958 traffic safety inventory.

But Racine also learned at the same time the high cost of those accidents which continue. The price tag: $2,900,000 annually in loss of earning power, medical and hospital expenses, cost of motor vehicle repair and replacement and the cost of providing automobile insurance; an estimated $35 for every man, woman and child in the city.

CRIME

Look Out For This Patient

The State Crime Laboratory has issued a warning to all physicians and hospitals on a person known by several aliases, including **Jan Piavia, Janes V. Lee** and **Kenneth F. Miles.**

Piavia, who is about 32, weighs 110–135 and stands five-foot-six, has got a clever criminal twist. Recently he entered a Milwaukee hospital with a supposed injury, ordered expensive jewelry on credit from a local shop, then checked out with merchandise in hand.

He often hits physicians and hospitals for narcotics allegedly to relieve pain, issues bogus checks or leaves without paying.

Authorities state that Piavia is tattoed (wolf's head on stomach, pig on left leg), has a slight hump back, with scars on chest, back and shoulders. He has light brown hair.

When last seen Piavia was driving a light blue 1954 Lincoln with Nebraska license plates. Contact local or Milwaukee police.

CHILDREN AND YOUTH

Physical Exams

The bill requiring physical examinations, including x-ray and tuberculin tests, of county superintendents, supervising teachers, and other county and state public instruction department personnel who work with children, has been signed into law by Gov. Gaylord Nelson.

Blank examination forms will be supplied personnel by local school boards.

Existing statutes cover all other school employees.

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MILWAUKEE WISCONSIN

ATHLETIC INJURIES CLINIC at Eau Claire stressed that physicians should be on the bench at every sport event. Panelists discussing new regulations for athletics included (. to r.) Dr. James C. H. Russell, Fort Atkinson; William Terrill, superintendent, Menominee high school; Jack Tetzner, athletic director, Thorp high school; and Dr. David MacMillan, Barron.

LOOKING OVER modern football helmets are (left) Dr. F. W. Reichardt, Stevens Point and Dr. C. M. Ihle, Eau Claire. Clinic brought out that the best equipment is "wasted" unless properly fitted.

SPORTS

Athletic Injuries Clinic

In an effort to cut down athletic injuries in Wisconsin high schools (7,100 last year), the Charitable, Educational and Scientific Foundation of the State Medical Society presented a special clinic at Eau Claire on October 8.

An estimated 225 high school coaches, administrators, athletic officials, physical education instructors and physicians showed up for the afternoon event from a 15-county area. (In numbers, this regional clinic easily matched the success of the first such *state-wide* clinic, held in Milwaukee last fall, when just three times that many attended.)

In opening the meeting, Dr. Thomas Kilkenny, Eau Claire, pointed out that "such is the purpose of our Fondation" that it can sponsor events as the injuries clinic which served public and profession simultaneously.

Four major topics were covered by almost a dozen speakers: athletic conditioning and safety, head and abdominal injuries on the playing field, leg injuries and needed athletic regulations.

Dr. C. M. Ihle, Eau Claire, set the tone of the clinic: "For many years the doctor was considered to be a hindrance to the athletic program".

But, he continued, "today, the coach, the trainer and the doctor . . . combine in one effective united to maintain the players in the best mental and physical condition." And, he emphasized, such close cooperation has led to a decrease in number and severity of injuries.

"Invite the doctor to sit on the bench" was the advice given football coaches.

George Wastila, University of Wisconsin athletic trainer, struck a warning note on conditioning: each sport needs its own type of training. A football player can't safely make the switch to basketball without special drills.

"Too much sleep is not a good conditioner," he said. He added that the most effective drill practice is at the same tempo as the game and under game conditions, not with handicaps.

A demonstration of football gear, from the old 1914 helmets up to today's plastic ones, was provided by Ed. Reutinger of the Wilson Sporting Goods Co.

His admonition: "Good equipment, while vital, is completely wasted unless properly fitted."

Dr. Anthony Curreri, professor of surgery, University of Wisconsin, told coaches that the decisions they make on the field "might change the entire course of an injured athlete's life."

"If you have any doubt as to the seriousness of an injury, don't hesitate, consult a doctor immediately," he said.

Dr. F. W. Reichardt, Stevens Point, brought up an interesting statistic: "We have too many shin bone fractures." He noted that 30 per cent of leg injuries are to the lower leg bones. He also called the knee most vulnerable to injury and the hip the least.

The panel on athletic regulations cheerfully disagreed on the present ruling which prohibits a player from competing within three days after suffering an injury, requiring a doctor's care. Dr. James Russell, Fort Atkinson, upheld it while Dr. David MacMillan, Barron, felt that the individual physician should be allowed to make the judgment.

HOSPITALS

UW Room Rates UP?

University of Wisconsin reported last month that the financial troubles at its hospitals are worsening because of a steadily reducing patient load.

Their proposal: raise room rates from $25 to $27 a day for both public and private patients, including the thousands annually sent to the hospitals from counties as public charges.

However, the state board of government operations temporarily postponed room rate action, expressing the doubt that the patient deficit could be cured by raising charges. Instead a study of other possible measures will be made.

The UW hospital reported its present operating deficit will amount to about $500,000 a year. Some 175 of its 715 beds have been empty lately.

CHILDREN AND YOUTH

Changes in Bicillin Program

Upon the recommendation of the Division on Handicapped Children (SMS Commission on State Departments), current eligibility rules for the Bicillin Prophylaxis Program have been changed.

Certified board members in pediatrics and internal medicine can request Bicillin at a reduced rate (5¢ a tablet) for eligible patients with rheumatic fever or congenital heart disease *without* having them visit one of the Wisconsin Heart Association mobile clinics, the University Hospitals clinics, or the Visiting Nurse Service clinic at St. Mary's Hospital, Madison.

In explaining the modification in rules, Dr. James W. Nellen, Green Bay, chairman of the Division on Handicapped Children, emphasized that the change was made to accomodate parents. It saves them an additional trip to a clinic for evaluation and certification.

"As more physicians become aware of this program there have been more requests for service," said Doctor Nellen. "We feel that in certain instances—where physicians because of the limited nature of their practice see more than an average amount of rheumatic fever or congenital heart disease in children—we can expedite the program by not requiring these selected patients to be seen at one of the clinics indicated," he continued.

"We feel the modified rules will be helpful to physicians and parents of patients alike," Doctor Nellen stated.

The basic details of the Bicillin program are outlined on page 372 of the *Journal* for July, 1959. With the exception of the modification noted above (applying only to physicians who are board members of pediatrics and internal medicine), the regulations stand as published in July.

TUBERCULOSIS

Sanatoriums Praised

Speaking before an annual joint meeting of Wisconsin Sanatorium Trustees and Superintendents associations. Dr. Jay Arthur Myers, Minneapolis, had nothing but praise for Wisconsin's t.b. sanatoriums.

They are providing maximum community protection at minimum cost to taxpayers, said Dr. Myers.

Wisconsin's ratio of employes to patients is the lowest among midwest states having many sanatoriums, he reported. The weekly cost of operation is lower than in any of these states, except Indiana.

Dr. Myers warned against premature closing of any such sanatorium since tuberculosis is still "America's number one infectious disease killer".

PROFESSIONAL BUSINESS SERVICE
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Business Consultants to the Medical Profession.

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STATE AFFAIRS

APPOINTMENTS

Dept. of Public Welfare

Following passage of a law by the 1959 Legislature, the State Dept. of Public Welfare is empowered to "create a program relating to the establishment of community mental health clinic services and providing for state grants-in-aid to local communities to encourage and assist them in the development and operation of preventive, educational, diagnostic treatment and rehabilitative services for mental health."

To enlist broad support in developing rules and standards for community mental health clinics (16 are now in existance, others are in the planning stage), Public Welfare has appointed the following to a Citizens' Advisory Committee:

Mrs. T. M. Ager, Eau Claire; Harold F. Borenz, M. D., Madison; Mrs. Otto L. Falk, Oconomowoc; Fred Holt, Janesville; Alfred L. Kasprowicz, Waukesha; Charles Landis, M. D., Milwaukee; Judge Charles D. Madison, Polk county; E. H. Pawsat, M. D., Fond du Lac; Miss Gertrude Reiman, Ph.D., Milwaukee; Harold T. Schroeder, M. D., Racine; Franklin Walsh, Hebron.

TALES

Wiggley Piggley

What do you do when suddenly in a hometown contest you get lucky and win a pig?

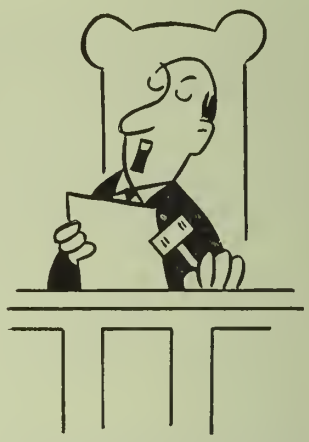
Dr. Robert H. Rifleman, Stevens Point, (who, despite his name, went "navy" during World War II, served on Admiral Spruance's staff at the height of the Pacific campaigns) thought he knew: pen the pig up in a friend's fenced yard. But the contest had just begun.

The porker refused to surrender, wiggled out of the gate and escaped. Not for long: with the help of heroic neighbors the cocky cutlet was chased and captured, this time confined in a box.

Again the porker refused to surrender, wriggled out of the box and escaped. Next day the local gendarmes stepped in, trapped the haughty ham at a downtown intersection, hauled him off to the county sheriff's farm. End of contest.

"DR. WILSON CUNNINGHAM DAY" was celebrated by grateful citizens of Platteville recently to salute a physician, now 87, who has watched over their health and guided them in numberless community enterprises for the last 59 years. Pictured above is (l. to r.) Dr. William D. Stovall, Dr. Cunningham, Dr. Carl Andrew and Dr. E. M. Dessloch.

Drs. Stovall and Dessloch were on hand to present a silver tray from SMS bearing the legend: "Wilson Cunningham, M. D., Father of Medicine in Southwestern Wisconsin," a title bestowed upon him long ago by the people of Platteville.



LAW OF THE LAND

Facts

(1) The patient is a female who is married but not of age. Her husband is over 21.

(2) The patient is a female who is married. Both husband and wife are minors.

Questions

Under either of the above fact situations who is the proper person to sign a consent for non-emergency surgery?

Answers

(1) Under the first fact situation the husband, assuming that he is mentally competent, would be the proper person to sign a consent to surgery on his wife. However, if the husband were incompetent or not available, and the female patient was rational and conscious to her acts, she could sign the consent for her own surgery.

(2) There appears to be no Wisconsin law on this question. However, it would seem that it would be legally sufficient if both the married minors signed the consent to surgery, and, if possible, the parents of both minors also signed. If that is not practical, a consent signed by the husband and the wife, if the latter is conscious, and by the husband if the wife is not conscious would suffice.

(Medico-legal comment has been prepared by the State Medical Society of Wisconsin in consultation with its legal counsel.)

REPORT ON CHIROPRACTOR CONVENTION

"The Full Benefits"

Wisconsin chiropractors gathered in Madison the last week-end in September with a new slogan emblazoned on their battle flag: "Social Justice".

The 300 delegates to the 48th annaul convention of the Wisconsin Chiropractic Association were enjoined to give their all in the noble cause of "procuring for the individual citizen the full benefits of chiropractic".

This, they were told, in a "professional political issue".

An editorial in the convention issue of the Journal of the association defined the problem and set forth the strategy.

For 48 years, the Journal said, chiropractors have been single-mindedly preoccupied with "chiropractic education and advancement", with the "scientific and technical" aspects of "their service to Wisconsin's citizens."

All through these long years, chiropractors developed a "thick-skinned indifference" to "misinterpretation of their education and the quality of their training and practice".

Such "generosity."

Moreover, chiropractors "gave certain patients free service because they need chiropractic care for a condition which is a public health obligation, but for which there is no administrative provision for payment for chiropractic care".

Such "professional preoccupation", and such "generosity" may be "commendable", the delegates were told, but it is "misplaced".

Chiropractors "can no longer tolerate limitations of the role of chiropractic in public health care". By doing so they are "actually aiding and abetting" a system "which denies complete freedom of choice of health care to all of Wisconsin's citizens".

This easy-going tolerance, the chiropractors were told, "is no longer a virtue, or a mark of professional maturity".

Chiropractors "must prepare to face facts and call them by their right name in Wisconsin". At the same time chiropractors must be informed "of the very latest developments in the chiropractic area of public health care".

"Resolution of Rebuke."

The convention managers then proceeded to carry out this double-barreled objective.

The very first order of business at the convention was the enthusiastic approval of a "resolution of rebuke" directed at the Wisconsin State Chamber of Commerce.

The WPA has been a member of the state Chamber for many years.

The object of the convention's fury was a statement in the Chamber's bulletin that the Chamber "took the lead to help defeat many bad bills in the past session of the Legislature. Among the bills where we were most active was 133A, authorizing chiropractic treatment of workmen's compensation cases".

At the state convention of chiropractors the following were elected to official posts: Gene C. Rohloff, Milwaukee, president; A. V. Fenander, Ladysmith, vice president; H. A. Naidl, Manitowoc, financial secretary, and Donald L. Lamoureaux, Wisconsin Rapids, treasurer.

This action by the Chamber, the resolution asserted, "ignored the democratic principles of treating its members, licensed as members of the healing arts profession, on an equal basis, thereby favoring one profession over and above another".

A resolution directed against a Chamber of Commerce by one of its members is sure-fire newspaper copy. The story was picked up by the wire services and was used routinely by many newspapers throughout the state.

Golden "Kentuckiana."

Thus ended the "fact-facing and naming" phase of the convention. The second phase—that of "describing chiropractic's role in public health"—fell largely upon **Lorraine M. Golden**, director of "Kentuckiana", which was described as a "children's chiropractic center".

A publicity release described Miss Golden as "founder, director and president" of Kentuckiana and noted that she received honorary distinction from the state of Kentucky in 1958, when she was commissioned a Kentucky Colonel, "in recognition of her many contributions to humanity".

Listening to Miss Golden describe the miracles wrought at Kentuckiana, some observers couldn't help but feel that a Nobel Prize would have been a more fitting reward.

The center has a capacity of 262 children, she said. More than 80 per cent of these "are hopeless, chronic cases", who came to the center with a "variety of conditions", including heart disturbances, defects of speech ,hearing and vision, cerebral palsy, post-polio difficulties, and spinal injuries.

The Fountainhead.

Among these 80 per cent of the children, with chronic ailments, Miss Golden asserted, there was "improvement" in 75 per cent of the cases. The degree of improvement was not specified, although Miss Golden promised that several years hence statistical matter on this score will be available.

Kentuckiana seems to be headed for enshrinement in chiropractic lore alongside the fountainhead in Davenport, Ia.

The "ultimate goal" of chiropractic, Miss Golden said, is to have children's centers like Kentuckiana "in every state of the union and in every province of Canada".

* * *

The "public service" note was also sounded in discussions about chiropractic "education". A conven-

POISON CONTROL

Kenosha

OLympic 4–5311, Poison Information Center, Kenosha Hospital, Kenosha.

Madison

ALpine 6–6811, University Hospitals Poison Information Center, Madison.

Milwaukee

DIvision 4–7100, Poison Control Center, Children's Hospital, Milwaukee

tion paper noted that Johns Hopkins University "recently announced plans to train doctors of medicine in a shorter period". The plain implication here was that schools of medicine would do well to pursue this approach rather than criticize the curriculum in chiropractic "colleges".

"Happy Report."

After all, the report continued, there is a "severe shortage of doctors in the country". While medical schools "are dragging out" their training period, "the chiropractic profession is happy to report that it is supplying a service which will increase the number of health practitioners available to take care of our citizens".

There was a hint, too, that chiropractic "education" should be reexamined to see if "the dragging out" could be reduced. The convention program noted, rather impatiently and with Capital Letters for emphasis, that the chiropractic college "curriculum" already included Chiropractic Principles and Practices, X-Ray, "Palpation, Orthopedy and Arthrology", and such "special subjects" as "Jurisprudence and Office Procedure".

Which of these "subjects" might be eliminated in the cause of "educating" more "Health practitioners" was not specified.

The "scientific and educational" program at the convention featured "Dr." J. Lemoine De Rusha, "Dean" of Northwestern College of Chiropractic in Minneapolis, who spoke on two subjects. "Conditions of the Neck and Thoracic Regions Common in Insurance and Workman's Compensation Cases", and "Diagnosis, Chiropractic Care and Management of Cerebral Palsy".

The convention, of course, wasn't all "work". There was fun, too, particularly at an informal party, which was billed, with no trace of self-consciousness, "WCA Varieties".

LA CROSSE COUNTY

Heart Clinic

A rheumatic fever and congenital heart disease clinic was held in La Crosse early in the month.

Sponsored by the Wisconsin Heart Association and the La Crosse County Medical Society, the clinic handled 25 patients who were referred by their physicians.

INSURANCE

Wisconsin Coverage Up

The number of persons in Wisconsin with health insurance increased by 86,000 last year to reach a total of 2,726,000 at the end of 1958, the Health Insurance Institute has reported.

The figure represents 70.6% of the state's population, on par with the national average.

All of the 2,726,000 had some form of hospital expense insurance. In addition, the number carrying surgical expense climbed from 93,000 to 2,523,000 (65% of the state's population), while the total of those protected by medical expense insurance rose from 55,000 to 1,691,000 (43.7%).

BOARD OF HEALTH

Appointments

State Board of Health has announced the appointment of Sister Blance Robinson, Milwaukee, as a member of the advisory hospital council and advisory committee on hospital regulation and approval.

Theodore N. Savides, Merrimac, has been appointed to the advisory committee on nursing homes.

MEDICARE

Regulations and Reminders

Even with permits and authorization papers a dependent eligible for Medicare can obtain just so much medical care from civilian sources. The conditions and limitations are set forth in the governing regulations.

For instance, medical care is *not* authorized for:

1. Outpatient care and/or service per se of any nature except maternity care and direct complications.
2. Nervous and mental diseases (acute emotional disorders).
3. Elective (plannable) surgery. Example: tonsillectomy, cosmetic surgery, hysterectomy (routine), heart surgery, rhinoplasties and reconstructive orthopedic and plastic procedures.

Caution: The Medicare permit issued by an Armed Forces officer does not make care automatically compensable. The physician himself must decide whether or not the service is compensable under the restricted program.

Certification: The lower half of Item 29 (certification of physician or dentist) of Medicare Form DA 1863 must be completed by checking either "A" or "B" which reads as follows:

A. I will accept the amount listed in the Dependent's Medical Care Program schedule of allowances or the amount shown in Item 24, whichever is less, as full payment for the services described above.

B. I will accept the amount shown in Item 24 *(which is supported by the attached special report as justification for services of unusual degree or for authorized services not covered in the schedule of allowances)* upon approval and payment by the government as full payment for services described in the attached report.

If "A" is checked, the State Medical Society can generally pay the claim immediately.

If "B" is checked, the claim must go to SMS Physician Claims Committee for review, then to the Office of Dependents 'Medical Care, and then from ODMC to the Society office for final disposition.

THE WISCONSIN MEDICAL JOURNAL

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Pancreatitis

By JAMES D. WHIFFEN, M. D.*

Modison, Wisconsin

ONE OF THE MOST provocative complaints a patient can present a surgical service is that of acute upper abdominal pain. Almost invariably at some point during the examination the possibility of pancreatitis will be raised and confirmed or dismissed by the appropriate laboratory procedures. This portion of the differential diagnosis is extremely important as an acute episode of pancreatitis, in which the therapeutic approach is primarily nonsurgical; and can, by history and physical examination alone, mimic most of the acute abdominal surgical emergencies.

Case Report

A 68-year-old white male was admitted to the hospital complaining of sharp epigastric and midabdominal pain. He dated the onset of the present episode to the night before, which was New Year's Eve, when he had consumed numerous alcoholic drinks and some fresh shrimp. The pain was sharp and fairly constant in character and on occasion would radiate to the small of the back. Frequent waves of nausea and vomiting were a part of the illness. Neither a bowel movement, vomiting, nor ingestion of antacids would affect the pain. There had been no change in the color of his skin or stools. This was the most severe of three such episodes which he had experienced during the previous 31 months. He had lost 24 pounds during this period.

Four years prior to the present admission he had been hospitalized complaining of right upper quadrant pain associated with mild jaundice, nausea, vomiting, and excessive gas. A diagnosis of cholecystitis was made and he improved on medical management. The hospital course was complicated by hypertensive heart disease and two bouts of acute pulmonary edema. By x-ray the gallbladder was found to contain a single large stone. When he was in optimal condition, an interval cholecystectomy was performed and the presence of a single stone confirmed. The common duct was noted to be of normal size. An operative cholangiogram was read as free of filling defects and so the duct was not explored. The postoperative course was smooth and he was discharged on digitalis and a low sodium and reduced fat diet.

On physical examination the patient was found to be asthenic, apprehensive, and in acute abdominal distress. Blood pressure 172 systolic, 104 diastolic, pulse 104, respirations 22 and temperature 99.8 F. The skin was loose and moist and without evidence of jaundice. The sclerae were clear. On fundiscopic examination grade two hypertensive retinopathy was noted. The lung fields were clear on auscultation. There was a grade two harsh systolic murmur at the apex and right base of the heart. The point of maximum impulse was in the left midclavicular line. The cardiac rhythm was regular. The pulmonary second sound was louder than the aortic second sound. The bowel sounds were hypoactive and the abdomen tense but not boardlike. There was generalized abdominal tenderness, being most severe in the lower epigastrium. The liver, spleen, and kidneys were not palpable.

Laboratory findings were as follows: hemoglobin 14.8 gm., white blood cell count 12,650 with 94% neutrophils, one band, 3 lymphocytes and 2 monocytes, urinalysis negative, blood sugar 100 mg., total protein 5.25

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gm., albumin 2.9 gm., globulin 2.35 gm., alkaline phosphatase 4.6 Bodansky units, direct bilirubin 2.9 mg., indirect bilirubin 4.1 mg., calcium 9.3 mg.%, admission serum amylase 872 Somogyi units, second day 642 units, third day 332 units, seventh day 132 units, and tenth day 154 units.

Abdominal x-rays at the time of admission showed on ileus and what appeared to be several flecks of calcification in the area of the pancreas. The patient improved and became asymptomatic on treatment consisting of continuous gastric suction, atropine, blood transfusions and intravenous fluids. An intravenous cholangiogram showed the common bile duct to be slightly enlarged. The heart was well compensated and the patient in good condition permitting an operation to be performed on the thirty-first hospital day. The enlargement of the common duct was confirmed. The pancreas proved to be of normal size but firm and fibrotic on palpation. The rest of the abdominal exploration was unremarkable. The common duct was opened and explored. No stones or obvious areas of obstruction were found. A transduodenal sphincterotomy of the sphincter of Oddi was performed. The postoperative course was uneventful. At two-year follow-up the patient had remained symptom-free and had gained 21 pounds.

Etiology

The acute episodes of pancreatitis are caused by the escape of the enzymes of pancreatic juice through acinar cells, as a result of obstruction, by bacterial invasion, or as a result of rupture of a large vessel with sudden hemorrhage into the organ. Chronic relapsing pancreatitis is a process of reoccurring episodes of acute pancreatitis with eventual fibrotic and calcific changes of the glandular tissue of the pancreas.[1]

Obstruction of the pancreatic duct system is by far the most commonly blamed precipitating factor in chronic relapsing pancreatitis and the site of obstruction is most often at the sphincter of Oddi. Mulholland and Doubilet[2] feel that the main component of the obstruction is sphincteric spasm. They feel that rarely actual fibrosis and stenosis may be present resulting from an inflammatory process around a stone impacted or temporarily impacted at the ampulla of Vater or due to previous operative damage.

Alcoholism at times seems to be an important factor in the pathogenesis of pancreatitis. Alcohol is known to cause a duodenitis with resulting sphincteric spasm.

Occasionally personality disorders have been associated with this disease.[3]

Signs and Symptoms

During an acute attack abdominal pain is the cardinal presenting symptom. The frequent occurrence of a history of alcohol ingestion just before an attack is striking. It is also frequently found that the pain is precipitated or increased by eating, hence an associated weight loss is common.

Bliss *et al.*[4] demonstrated the areas of referred pain by electrical stimulation of the pancreas. They found that stimulation of the head of the pancreas was referred to the right epigastrium; stimulation of the body to the left lower epigastrium; and stimulation of the tail to the left lower epigastrium and, on occasion, to the left lower quadrant. Simultaneous stimulation of all three areas produced a band-like pain across the epigastrium with radiation to the back.

Biliary tract disease is present in over 50 per cent of patients with pancreatitis.[5] Therefore, any or all of the following may be a part of the history: intolerance to fats, colicky right upper quadrant pain with radiation to the back below the shoulder blades, increased gas, jaundice, and light stools.

Depending upon the degree of impairment of the pancreas, the stools may or may not be bulky and fatty, and a diabetic state may or may not ensue.

Fairly common physical findings are epigastric tenderness, paralytic ileus and mild tachycardia. Jaundice and physically demonstrable ascities are infrequently present. On a few occasions, cutaneous manifestations of acute pancreatitis have been reported.[6] They take the form of: a bluish patch of discoloration about the umbilicus (Grey-Turner or less specifically Cullen's sign); small plaques of firm edema on the abdomen, or finally, livedo reticularis may appear.

Laboratory Procedures

In the diagnosis of an acute exacerbation of pancreatitis the most useful procedure is the blood amylase determination. In the near future another enzyme, desoxyribonuclease, may be found to be more specific and of greater prognostic and diagnostic significance.[7] The serum amylase (normal 40 to 130 Somogyi units) is elevated early in the attack falling to normal levels on the third or

fourth day.[8] The amylase levels of the peritoneal fluid, however, may remain significantly increased (300 to 1,000 Somogyi units) for two to three days after the blood level has fallen to non-diagnostic ranges.[9]

Protracted hyperamylasemia usually indicates the formation of a pseudocyst or peripancreatic collection of pancreatic secretions. On the other hand subnormal levels of circulating amylase may be indicative of chronic fibrotic destruction of the pancreas, carcinoma of the pancreas, or cirrhosis of the liver.

Unfortunately pancreatitis is not the sole disease associated with hyperamylasemia.[7] The serum amylase may also be elevated in inflammations of the parotid glands, advanced renal disease (due to slowed renal excretion), perforated ulcer and any process causing gangrenous bowel. In the latter two conditions amylase in the intestine apparently diffuses through the now permeable dying bowel into the peritoneal cavity and is absorbed into the blood stream.[10]

Serum lipase may remain increased for a longer period of time than does the amylase.[11] Therefore, in patients admitted late in the course of an acute episode, evidence of the condition may be determined by an elevated serum lipase even though the amylase has returned to normal levels.

A simple urine test for increased pancreatic enzymes is described by Sachar.[12] This test is especially useful when a kidney barrier is suspected to have caused elevated blood levels of the enzymes.

A radiographic finding almost diagnostic of chronic relapsing pancreatitis is calcification in the region of the pancreas. Since gallbladder disease is also present about half the time, gallstones are commonly noted. During an acute exacerbation, a paralytic ileus and widening of the duodenal loop are radiographic evidence to look for. There also may be a pleural effusion in the left lower chest due to lymphatic interchange.[13]

Differential Diagnosis

The differential diagnosis of an acute episode of pancreatitis may be quite difficult because it may mimic almost any acute abdominal condition. The three most frequently imitated are: cholecystitis, duodenal and gastric ulcers and their complications, and gangrenous bowel.

In cholecystitis the palpation of a tender mass in the right upper quadrant makes matters more clear. A normal serum amylase will generally make the distinction here. Infrequently an elevated serum amylase has been noted during an episode of acute cholecystitis, the mechanism not being clear unless it represents a mild concurrent pancreatitis.

Active duodenal or gastric ulcers do not show hyperamylasemia unless their inflammatory reactions are penetrating into the pancreas and causing a zone of pancreatitis, or they perforate and allow the pancreatic secretions in the gut to pass into the peritoneal cavity and be absorbed into the blood stream. If perforation has occurred, an upright film of the abdomen may show free air. A peritoneal tap is frequently helpful here in that hydrochloric acid, bile, and gram-negative bacilli may be recovered. The peritoneal fluid in pancreatitis will contain only white blood cells.

A gangrenous bowel due to volvulus, internal hernia, or mesenteric thrombosis frequently causes hyperamylasemia. Here again examination of peritoneal fluid may well show gram-negative bacilli. Some of the highest peritoneal amylases discovered have been the result of gangrenous bowel. Ellison, as quoted by Gray and Amador, feels a peritoneal amylase over 1,000 units is strongly suggestive of necrotic intestine rather than of pancreatic disease.[10]

Treatment

The basic aim in the treatment of an acute episode is to put the pancreas at physiologic rest.[5] The secretory stimulus of a bolus and hydrochloric acid in the duodenum is eliminated by placing the patient on nothing by mouth and on nasogastric suction. Gastric and pancreatic secretions are further suppressed by cholinergic blocking agents such as atropine or propantheline.

The next line of therapy is supportive and symptomatic. Kenwell and Wels noted a decrease in blood volume in patients with acute pancreatitis while studying the antitryptic activity of serum albumin and first advocated treatment with human serum albumin.[14] Keith and Watman found an average whole blood volume deficit of 30 per cent, or 1500 cc., while studying 28 cases of acute and chronic pancreatitis.[5]

The relief of pain is essential to the patient's comfort. Due to the spasmogenic properties of morphine on the sphincter of Oddi, it is to be avoided. Meperidine has much less effect on the duodenal musculature. If spasm

of the sphincter of Oddi is an important factor in increased pancreatic and biliary pressure, nitroglycerin or amyl nitrate may bring dramatic relief of pain.

Antibiotics may be employed as a prophylactic measure.

Hypocalcinemia may tend to complicate acute fulminating pancreatitis. Moyer feels that the fixation of large amounts of calcium in the tissues and exudates probably accounts for the development of calcium deficiency in the blood stream.[15] He notes that the conversion of less than 10 gm. of fatty acids to calcium soap will remove from circulation as much ionized calcium as is normally present in the whole of the extracellular fluid and that when removal of such amounts is rapid, as it is in fulminating acute pancreatitis complicated by pancreatic necrosis of fat, mobilization of calcium evidently cannot keep up, and serum calcium levels may drop 5 mg.% in 36 hours. Therefore, calcium may have to be administered intravenously in the fulminating case.

Raker and Bartlett noted a mortality of 12% in 134 patients with acute pancreatitis.[16] They followed the 118 who survived the acute attack and found the majority did not sustain succeeding attacks and also found that the chance of a succeeding attack was materially lessened if cholecystectomy and/or correction of any disease of the biliary tree had been accomplished. If, however, the disease does become recurrent, then chronic or recurrent obstruction of the pancreatic duct system may be assumed.

Surgical approaches to the problem of obstruction vary from sphincterotomy for ampullary or sphincteric obstruction to pancreatic shunt procedures for recurrent pancreatic duct stones. On some occasions when direct attack on the obstruction is impossible or has failed, vagotomy and partial gastric resection has given relief.

Summary

A discussion of the etiology, diagnosis, differential diagnosis, and treatment of pancreatitis is presented. A case illustrating certain areas of the discussion is reviewed.

35 Bayside Drive.

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A Critical Review of 515* Consecutive Surgical Cases From a Small Community-Type Hospital

By HARRIS A. WEISSE, M. D., A. I. C. S., F. A. C. O. G.

Plymouth, Wisconsin

THIS SERIES IS reported to indicate the variety of work performed and the complications encountered in a consecutive unselected surgical series covering the years 1952 through 1958 at the Plymouth Hospital, Plymouth, Wisconsin, a 60-bed community hospital serving an area of approximately 15,000.

Procedures ranged from saphenous ligations and hemorrhoidectomies to extensive pelvic operations, bowel resections, and gastrectomies.

Ages of patients varied from a few hours after birth (exchange transfusions) to age 90 (mastectomy).

Appendectomies involved primarily children and adolescents with most of the perforated cases involving adults. In this group were 5 cases of acute mesenteric adenitis, 2 of Meckel's diverticulitis, and 1 perforated duodenal ulcer simulating appendicitis.

Hysterectomies were indicated to relieve abnormal bleeding and/or pelvic pain with the most common diagnoses being chronic salpingitis, endometriosis, myomata uteri, and prolapse. One subtotal hysterectomy was done in association with re-operation for intestinal obstruction after myomectomy. One total hysterectomy was done postpartum to arrest uterine hemorrhage uncontrolled with emptying of uterine cavity and intravenous oxytocics. Three women have had re-operations, following total hysterectomy 3 to 12 months prior, for removal of symptomatic ovarian pathology. In most cases over the age of 40, bilateral salpingo-oophorectomy was performed at the time of abdominal hysterectomy. Incidental appendectomy was done routinely during all abdominal procedures when exposure was adequate. One young woman with a two-year pelvic inflammatory problem developed a vesicovaginal fistula 3 months after total abdominal hysterectomy. A second attempt at closure 10 months later was successful. To date there has been no problem with vaginal prolapse or enterocoele. At least part of this success can be attributed to the routine of purse-string obliteration of posterior cul-de-sacs of Douglas utilizing the uterosacral ligaments.

Vaginal surgery has resulted in one localized infection which cleared promptly after the passage of a retained surgical sponge 5 weeks postoperatively. Whenever possible the lateral uterine ligaments (round, cardinal, and uterosacral) are sutured together. This maneuver provides better support of the vaginal apex and appears to prevent the prolapse of retained tube or omentum into the vagina. During vaginal hysterectomy, all clamped structures are doubly ligated with transfixion sutures of chromic 1 catgut. There have been no cases of postoperative hemorrhage to date. Aqueous benzalkonium chloride (Zephiran chloride) douches are routinely employed.

Biliary surgery has not been performed in the absence of a diagnosis of cholelithiasis. The usual criteria for choledochostomy have been observed: presence of jaundice, small calculi or bile paste in gallbladder, small shrunken gallbladder, white dilated common duct, palpable mass in common duct. One cholecystostomy was done to establish bile drainage in a pancreatitis case with increasing jaundice. Jaundice and fever cleared, but unfortunately the patient expired as a result of coronary occlusion on the 17th postoperative day. Nasogastric suction has been used routinely after choledochostomy and occasionally after cholecystectomy for 48 hours.

Stomach and intestinal surgery was indicated for persisting hemorrhage, mechanical obstruction, and malignancy. Two of the three deaths in this group were extremely poor risks.

* Approximately 90% performed by the author.

During the past 18 months, herniorrhaphies have followed the techniques of Zimmerman utilizing No. 24 cotton exclusively and occasionally fascia lata "patch" graft. Previously inguinal herniae were repaired by Fergusson, Bassini and Andrews' techniques.

Hemorrhoidectomies are done as radically as possible, generally leaving a "bridge" between resection of the three primary groups. Satellites are coagulated as are hemorrhoidal beds. Excellent relaxation and prolonged postoperative anesthesia have been achieved with heavy dibucaine hydrochloride (Nupercaine hydrochloride) saddle-block anesthesia.

Saphenous ligations were usually bilateral and associated with either stripping or injection. A 20-minute scrub with a combination of entsufon, lanolin cholesterols, petrolatum and hexachlorophene (pHisoHex) has alleviated annoying tiny "stitch abscess" infections in lower leg incisions.

Urologic operations have been indicated primarily for obstruction (calculi or malignancy) and infection. Ureterosigmoidostomy has resulted in recurrent severe pyelonephritis. Cystoscopy has been done routinely preoperatively.

Exchange transfusions were done between birth and 12 hours to relieve increasing jaundice in erythroblastotic newborn. Two were typical Rh-factor incompatabilities and one was an A-O incompatability. One required a second transfusion within 24 hours for recurring jaundice.

Of 17 surgical cancer patients in this series, 5 were palliative for metastases and all have succumbed; 2 were inoperable and expired within 3 months; 2 died of unrelated conditions and 1 died of metastatic disease. Seven are living and free of disease at this time. Cervical carcinoma has been treated primarily with radiation.

The Cesarean section rate was approximately 5% with repeat section, hemorrhage and toxemia the primary indications. The only serious complication, sigmoid obstruc-

TABLE 1—PROCEDURES AND COMPLICATIONS (NONFATAL)

PROCEDURES	Number	COMPLICATIONS (Nonfatal)									
		Phlebitis Pelvic	Embolus Pulmonary	Intestinal Obstruction	Adymanic Ileus	Incisional Recurrent Hernia	Vesicovaginal Fistula	Shock Severe	Footdrop	Wound Infection	Lymphedema Upper Extremity
Abdominal hysterectomy, total subtotal	87 1	1				1	1			1	
Other gynecologic abdominal surgery including: pelvic, neurectomy, tuboplastic, oophorectomy, ectopic, Marshall-Marchetti, etc.	25		2	1		1					
Vaginal surgery including: hysterectomy, enterocoele, A & P repair, and with removal retained cervix	57								1*	1	
Cesarean section, low cervical	25			1		1					
Appendectomy, acute and chronic perforated with peritonitis	90 7				7			1			
Hemorrhoidectomy Other anorectal including fistula, ischiorectal, etc.	49 12										
Cholecystectomy and choledochostomy	24 14					1				2	
Cholecystostomy	1										
Other gastrointestinal surgery including gastrectomy, large and small bowel resection	17										
Herniorrhaphy including femoral, inguinal, ventral, recurrent	48					3					
Urologic surgery including nephrectomy, ureterocolostomy, prostatectomy, orchiectomy	11										
Saphenous vein ligations and stripping	37										
Mastectomy	7										1
Exchange transfusions	3										
TOTAL	515										

*Spontaneous recovery 3 weeks.

Table 2—Deaths

	Expired	Surgery	Complication
1. A. D., age 55	5 days	Postoperative (Cholecystectomy and choledochostomy)	Acute hemorrhagic pancreatitis
2. R. S., age 68	17 days	Postoperative (Cholecystostomy)	Coronary occlusion
3. E. S., age 52	9 days	Postoperative (Partial gastrectomy)	Peritonitis
4. W. S., age 82	14 days	(Partial gastrectomy)	Evisceration and peritonitis
5. A. G., age 84	3 days	(Exploratory, Intestinal obstruction)	Acute fibrinous peritonitis

tion, occurred several days after a repeat section with a history of retained laparotomy pack after her first section with abscess formation and surgical removal and drainage. She was relieved by transversostomy. Closure was performed 5 weeks later.

Average hospital stay was 8 days, but varied from 1 day for herniorrhaphy of a 3-month-old to 1 month for prostatectomy of a 76-year-old patient.

Bladder infections were not uncommon but seldom resulted in more than a degree or two of fever and all cleared promptly on sulfisoxazole, chloramphenicol, or penicillin-streptomycin. Postoperative morbidity has not been reported because antibiotics (especially penicillin) have been employed more-orless routinely in most cases. Hospitalization was prolonged as much as 5 days because of a wound infection in one patient.

During the past year the intravenous routine (of Philip Thorek), 1,000 cc. of 5% glucose in 0.45% saline with 3 gm. of potassium chloride and a high potency multiple vitamin preparation with 1,000 mg. of vitamin C, has been given to over 100 patients as the only fluids (except blood replacement, if needed) during the first 24 hours after surgery. Urine output during these 24 hours has varied from 700 to 1,200 cc. Rarely in hot weather or with high fever has another 500 to 1,000 cc. of glucose in water been given.

Crochet cotton No. 10 retention sutures have been used in all obese abdominal closures without fat sutures during the past 18 months and no incisional herniae have occurred.

Postoperative shock was treated with Trendelenberg position, nasal oxygen, intravenous vasoconstrictors, fluids, blood, and when indicated, *l*-norepinephrine (Levophed). In one adult with perforated appendicitis, peritonitis, and auricular fibrillation, *l*-norepinephrine was needed for 72 hours to maintain blood pressure.

1000 Eastern Avenue.

Unique Medical Film Offered

A novel technique in medical communications—an educational motion picture utilizing techniques developed for commercial television programs—has been incorporated by Lakeside Laboratories, Inc., here in its film "A Pharmacologic Approach to the Study of the Mind" which has just been released for showing to the medical profession.

The subject matter is of prime interest to the medical profession and the film presents in a lucid and informal manner a comprehensive review of the field. Prominent authorities in the use of chemicals to diagnose and treat mental illness report on their theories and their clinical findings.

The first portion of the film reviews the use of hallucinogenic agents, and the second outlines the chemistry and clinical evaluation of monoamine oxidase inhibitors.

The film was produced by Sherman H. Dryer. It is available to professional groups, upon request, from the Medical Education Department, Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin.

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Experimental Protection Against Shock*

By S. G. HERSHEY, M. D.**

New York, New York

CLINICAL SHOCK occurring in the operating room is a well-recognized entity. Yet a critical definition of shock becomes an exercise in semantics leading to the conclusion that it cannot be unequivocally defined. But there is no doubt that shock is an actual clinical entity and a genuine clinical problem in therapy. By contrast, research related to shock is predominantly a laboratory problem focussed on what occurs in laboratory animals. This dichotomy between the laboratory and operating room is disappointingly real in that there has been surprisingly little traffic of laboratory findings toward the clinic. Present resources in the management of shock in patients are not much further developed than the use of blood transfusion, vasopressors and corticosteroids. The lack of more specific anti-shock therapy can obviously be attributed to the fact that the basic disturbances caused by severe stress have not yet been identified. While animal experimentation is primarily concerned with identifying these disturbances, it also seeks to develop therapy which can increase patients' tolerance to injury which might otherwise be lethal.

For some years, in many laboratories, research dealing with shock has incorporated procedures which protect animals against the irreversible sequelae of experimental injury. There are many such protective procedures which are predictable, effective and reproducable for most laboratory species. These protective procedures are diverse and seemingly unrelated to each other in terms of any obvious pharmacodynamic pathway as a common denominator of their activity. Of itself, the phenomenon of protection against shock, as a biologic entity, is not only extremely interesting but also of potential clinical value.

Actually the technics of controlled hypotension, artificial hibernation and hypothermia represent somewhat empiric but significant attempts to protect patients against severe surgical stress. More recently[1,2] there have been a few tenuous trials, in patients, of protective procedures more typical of those used in the laboratory. For a long time some of the measures found beneficial in shock in animals have been used freely in patients by coincidence rather than by design. These measures include the commonplace preoperative emptying of the gastrointestinal tract, preparation with antibiotics, and avoiding surgery in the presence of respiratory infections. The need to develop much more effective means of protecting patients against shock can best be epitomized by the fact that surgical therapy has virtually developed to a point at which its only limitation will soon be the patient's capacity to tolerate the stress required to effect his cure.

In considering protective procedures, they are each more meaningful if not regarded as isolated experimental situations but rather in terms of their relationships to the derangements associated with shock. For example, the effects of induced protection on the integrity of localized vascular beds provides a valuable index of their influence on the course of the shock syndrome since peripheral vascular deterioration is almost always a major element of the irreversible reaction to stress. Similarly the relationships of specific protective technics to the various factors implicated in the pathogenesis of shock furnishes another useful frame of reference. These relationships[3] afford a means of assessing the validity of mechanisms and concepts which have been postulated as criti-

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cal components of the shock response. In other words, modalities of protection against shock are research tools primarily and not yet to be regarded as therapeutic measures. As research tools, protective procedures afford a type of experimental dissection of the shock syndrome and permit observations more discriminating than might otherwise be possible. They bluntly re-emphasize that there is no single complete concept of the pathogenesis of shock which is considered valid.

A brief analysis of some of the typical methods of protection can serve to illustrate their essential characteristics. It can place in better perspective some of the factors and mechanisms involved in the response to stress. This analysis may also help to clarify the present tenuous but anticipated possibilities that protection against shock holds for patients.

Drum Trauma

The induction of resistance to tumbling trauma by placing rats in a rotating drum, as reported by Noble[4] in 1943, probably represents the contemporary initiation of experimental protection against shock. Animals periodically subjected to a sublethal number of drum revolutions become trained to withstand a degree of injury ordinarily highly lethal. These Commando rats, as they are sometimes called, are perhaps comparable to the conditioned boxers and athletes trained for contact athletics. After drumming, these rats, when compared with untrained controls, are active and show very little cutaneous bruising or visceral congestion and hemorrhage. In fact they develop virtually none of the biochemical, neurohumoral, or other stigmata,[5] typical of the irreversible stage of shock. The trauma tolerant rat shows cross resistance to hemorrhagic shock[6] and bowel ischemia[7] shock, but is not particularly resistant to the lethal effects of endotoxemia.[8] Interestingly, drum tolerance can be sustained by small doses of bacterial endotoxins substituted for the periodic drummings ordinarily necessary to maintain the drum tolerant state.

While the mechanism of drum protection is not clear, its relatively crude, nonspecific nature more than likely involves a variety rather than a single pathway of adaptation. Whatever adjustments these pathways entail, they are capable of averting the peripheral vascular decompensation characterizing the irreversible response to injury. Drum training may involve increased tolerance to the deleterious effects of vasoactive tissue amines[3] such as histamine and epinephrine. It definitely stimulates reticuloendothelial system activity but not the phagocytic function[9] of this system which has been related to the inactivation of bacterial endotoxins.[10] Drum adaptation may similarly affect proteolytic enzyme activity, antibody titers presumably associated with properdin,[11] and many of the other factors which have been implicated in the reaction to stress. Tumbling trauma is a relatively undifferentiated stimulus. While it has served to elucidate many significant characteristics and interrelationships of the experimental shock syndrome, it has not, per se, directed attention to any precise set of circumstances which categorically support or rule out any single concept of the pathogenesis of shock.

Antibiotic Pretreatment

The use of antibiotics to protect against shock is probably based on their ubiquitous relationship to the bacterial factors which have been implicated in the syndrome. Animals in shock do not effectively clear their blood and tissues of bacteria.[12] Such bacterial invasion whether endogenous or from outside sources (both circumstances have been described) definitely predisposes[13] to irreversibility. In fact, much of the data incriminating bacterial factors derive from the ability of antibiotics to circumvent the deleterious sequelae presumably due to bacteria and bacterial products. Apart from the unsettled status of the role of bacterial factors in shock, there is sufficient information to indicate that antibiotics given in generous quantities for several days prior to the onset of some types of experimental shock are definitely beneficial. This is valid for a wide variety of antibiotic drugs administered orally or parenterally. Antibiotics can protect against hemorrhage,[13] bowel ischemia[14] and to a lesser extent, drum trauma.[15] They are ineffectual in endotoxin shock.[16] On the whole antibiotics do not seem to be as dramatically beneficial[15] as several other methods of protection.

The most apparent explanation of antibiotic protection is that by reducing the bacterial content of the body's bacterial depots prior to the onset of stress, the quantity of noxious bacterial products, presumably elaborated during the shock episode, is reduced.

While there are a number of attractive observations supporting this explanation, they do little to clarify the confusing antibiotic story. For example, it may be contended that in the course of antibiotic pretreatment the attendant destruction of bacteria may simultaneously expose the animal to sublethal amounts of bacterial endotoxins released by these bacteria. This is comparable to the experimental method of using repeated small doses of exogenous endotoxins to achieve protective antibiotics, such as polymyxin, not resistant to endotoxemia per se. Some protective antibiotics, such as polymyxin, release tissue amines.[17] Their release, leaving the tissues relatively depleted of such amines, prior to the onset of shock, represents a known beneficial situation and may point to a mechanism of antibiotic protection unrelated to antibacterial activity. Antibiotics do not stimulate the reticuloendothelial system[18] which is a significant component of the body's defenses against bacteria and perhaps endotoxins. Yet, blockade of the reticuloendothelial system regularly abolishes preexisting antibiotic protection.[19] It would seem that experimental antibiotic protection, in emphasizing the importance of the "gut factor" in shock, has been of significant research value. But it must be assumed that the loose ends it leaves are of sufficient importance to preclude any arbitrary assumptions as to any specific shock mechanisms.

Endotoxin Tolerance

Animals such as the rat and rabbit can be made tolerant to lethal doses of bacterial endotoxins[3] by prior administration of sublethal doses for several days. A rationale of using endotoxin tolerance as a shock protective modality is provided by the fact that fatal endotoxemia is strikingly similar[7] to other types of experimental shock. In addition, there is extensive evidence establishing the relationship of endotoxins to the irreversible manifestations of shock.[12] It is also claimed[20] that the blood of fatally-shocked animals contains a material which exhibits many of the characteristics of endotoxins. Whether or not bacterial endotoxins are the primary offenders in the so-called "gut factor" in shock, if they are in fact present, they probably are elaborated in the bowel which seems to be a major tissue site of the events leading to irreversibility. When animals are made tolerant to large doses of endotoxin[7] they also show cross tolerance to hemorrhage and drum trauma. The endotoxin-resistant animal[9] shows increased activity of the reticuloendothelial system. Blockade of this system will not only predispose the normal animal to fatal endotoxemia but also will abolish existing[9] endotoxin tolerance.

It is also interesting that endotoxins may be substituted[21] for the periodic re-exposure to drum trauma necessary to sustain drum protection. The counterpart of this is also true in that drum exposure may replace the re-exposure to endotoxins necessary to sustain the endotoxin tolerant state.

At present the exact relationship of bacterial endotoxins to the course of the fatal shock syndrome is quite unsettled. It does seem, however, that in endotoxin shock the integrity of the small blood vessels[3] is particularly susceptible. In this respect the effects of endotoxins resemble those observed in situations of hypersensitivity[22] to vasoactive amines. Without relationship to shock per se, one of the principal consequences of the administration of endotoxins is a tremendously exaggerated response of small blood vessels to the catechol amines, epinephrine and norepinephrine. Despite a good deal of existing enthusiasm, it is unlikely that endotoxemia will prove to be the single common pathway leading to a fatal outcome in shock. This thesis leaves too many other factors unexplained. But there is no doubt that the research stimulated by studies with bacterial endotoxins has pointed to the significance of the release of vasoactive amines in the shock response. In this regard the homeostatic systems involving epinephrine and norepinephrine, somewhat nebulously dealt with, have been re-emphasized to the effect that their participation will now require more thorough exploration.

Reticuloendothelial Stimulation

The rationale of protecting animals against shock by preparatory stimulation of the reticuloendothelial system (RES) is based on observations showing a close functional relationship of this system to the course of events in shock. Shock is usually accompanied by a depression[21] of RES function. The experimentally protected animal, on the other hand, often shows enhanced RES activity.[3] Single large doses of various inert colloids, normally taken up by the cells of the RES to "blockade" them, depress their activity temporarily during which time these

animals[9] are predisposed to shock. This type of "mechanical" blockade of the RES will, in fact, abolish virtually every form of preexisting protection. As anticipated from experience with other types of experimental protection, several small, repeated doses of certain (saccharated iron, denatured serum proteins, CAG) but not all (thorium oxide, ovalbumin) inert colloids resulted in stimulation of the RES (measured by phagocytic function and carbon clearance) and protection against hemorrhage and drum trauma.[9] Such RES stimulated animals are not consistently resistant[23] to bacterial endotoxins.

In evaluating this form of protection in terms of mechanisms operative in shock, it must be emphasized that these colloidal materials probably do not stimulate all functions of the RES which probably participate in the syndrome. This is apparent in the fact that enhanced phagocytic activity is of no benefit in endotoxemia whereas in drum adaptation, which shows no stimulation of phagocytosis, there is present, nevertheless, an increase in RES activity. There is growing indication that the anatomically diffuse RES is functionally more diversified than previously recognized. In terms of the participation of this system in shock it must be assumed that this involves more than phagocytosis and RES functions, normally concerned with defenses against bacteria. Other less obvious activities[24] of the RES related to functional behavior of small blood vessels, clearance of purines, iron and proteolytic substances have been reported. Study of this tissue system in relation to shock is a relatively recent development which still has many gaps. But it does seem that the RES represents an important pathway whereby regional and systemic readjustments to stress are mediated.

Amine Depletion

Use of agents which deplete tissues of vasoactive amines, such as histamine, serotonin, epinephrine, etc., represents a relatively recent approach to inducing protection against shock. The potential value of amine depletion is predicated on observations that tissue amines produce vascular injury[25] resembling that seen in shock and that the small blood vessels are a prime target of many of the factors which lead to irreversibility. Single large doses of drugs which release amines and leave tissues depleted of them result in hypotension and rapid death of animals. But when given in several smaller doses[3] at daily intervals, rats can be made refractory to ordinarily lethal doses of these agents. There are many drugs which release amines but most of them are not pharmacologically pure. Reserpine, many of the tranquilizers, and autonomic blocking drugs are of this impure type. The drug 48/80 (condensation product of alkophenylalkylamine and formaldehyde) is a relatively pure amine releaser, and rats made tolerant to it[3] are also protected against hemorrhage, drum trauma, and endotoxemia. These resistant rats do not, however, show increased phagocytic activity[26] of the RES.

The apparent explanation of the beneficial action of amine depletion is that it preserves the integrity of a major target of the unfavorable shock reaction by making the peripheral vascular bed refractory to the effects of vasoactive amines. Like other methods of protection the use of amine depletion again represents the stimulation of an adaptive mechanism by repeated exposure to sublethal stress. The pharmacodynamic pathway of amine depletion seems somewhat more precise than with other methods of protection. It suggests that this pathway may also be involved in other protective procedures in that certain protective antibiotics[17] (polymyxin, neomycin) drum training[27] and protective autonomic drugs[28] are associated with amine release. Since vascular hyperreactivity to catechol amines often characterizes shock and has been suggested as an important mechanism leading to irreversibility,[29] protection by amine depletion has re-emphasized the role of epinephrine in the readjustment to injury.

Autonomic Blocking Drugs

Many drugs belonging to the broad category of autonomic blocking agents can protect animals against shock. Two of these drugs, dibenzyline (dibenamine) and chlorpromazine, have probably been more extensively studied than any other protective modality. While dibenzyline is not typical of all autonomic blockers, it is, perhaps, the most potent protective drug in common use. Depending upon the dose, route, and timing of its administration, all of the usual laboratory species can be protected by a single dose of dibenzyline given up to and even immediately after the onset of shock. This drug is effective in hemorrhage,[30] drum trauma,[13] bowel ischemia [31] and many other forms of stress

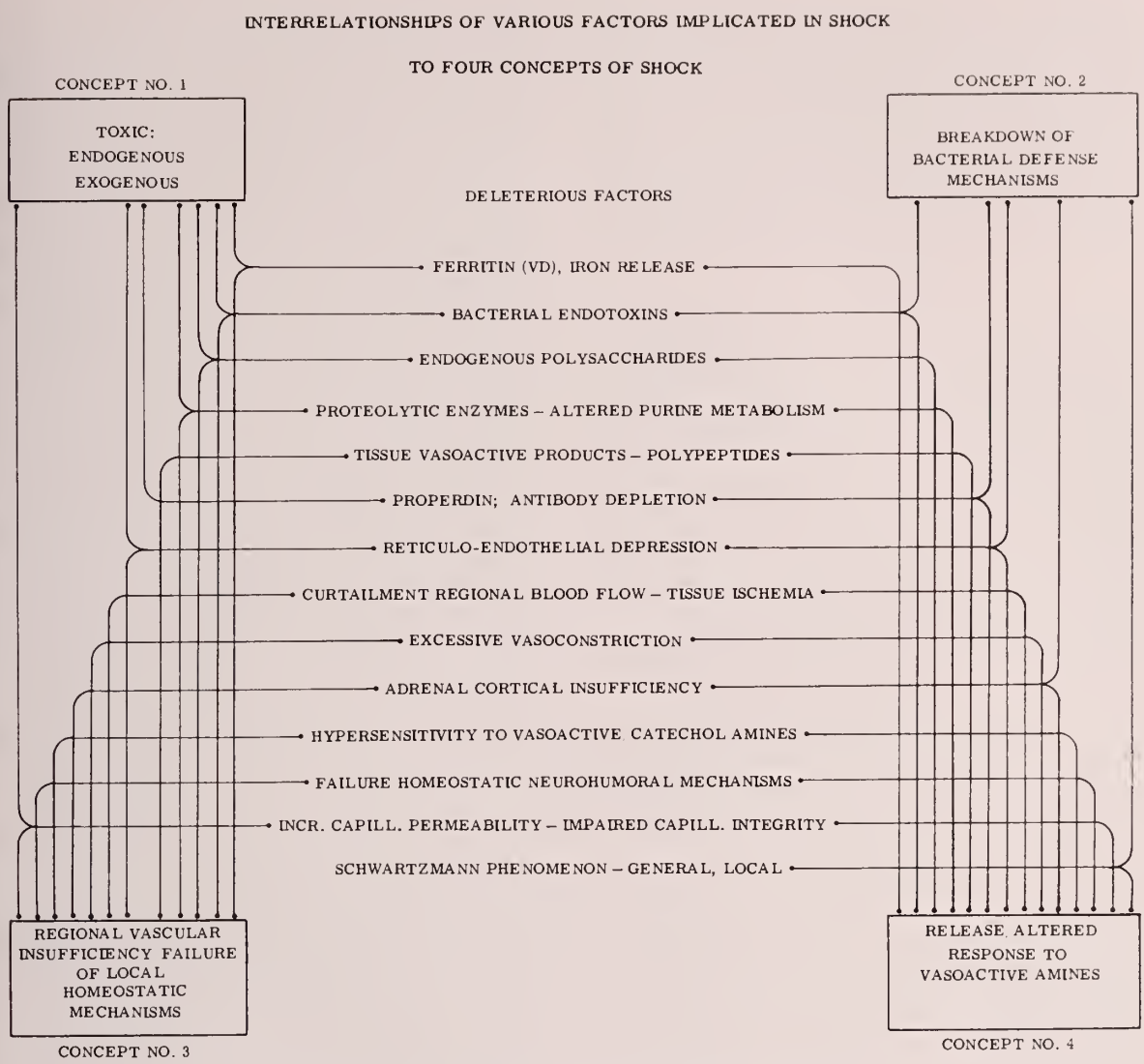

Fig. 1—This schema is illustrative of the text discussion. It does not include all known or inferred factors leading to irreversibility, nor all postulated concepts of the pathogenesis of shock.

which have been used experimentally. Although the documentation is not complete, observations with dibenzyline indicate that it can eliminate or attenuate many of the vascular, neurohumoral, and perhaps metabolic stigmata of irreversibility. But as with most forms of protection, the beneficial effects of dibenzyline are abolished by blockade of the reticuloendothelial system.

Pharmacologically, dibenzyline probably has a dual effect: vascular and metabolic. Like most autonomic blocking drugs, its adrenalytic action averts the undesirable intense peripheral vasoconstriction[32] characterizing the early "overcompensatory" phase of shock. This vascular effect tends to sustain tissue perfusion in the presence of hypotension and hypovolemia. It thereby reduces tissue hypoxia, the net result of which effect is, per se, beneficial. Beyond this circulatory mechanism, dibenzyline, like many other protective drugs (particularly phenothiazine derivatives) and procedures, has metabolic actions not directly related to its vasomotor blocking properties. Reports of such metabolic effects of dibenzyline, observed or implied, are accumulating rapidly. This drug seemingly has the capacity to modify the influence of a broad group of factors which have been implicated in the response to stress. Dibenzyline will block the ferritin[33] release, some actions of endotoxins,[34] histamine and vasoac-

tive amines.[35] It prevents the breakdown of phagocytosis[36] and perhaps other RES functions. While these properties do not necessarily identify precise metabolic pathways through which dibenzyline functions, they seemingly add up to the implication that this versatile drug suppresses the deleterious effects of the products of tissue damage generated by shock-producing stimuli.

Discussion

When several of the current broad concepts of shock are listed along with some of the mechanisms that may be related to each of them (fig. 1), it becomes apparent that the concepts themselves are not discrete from each other. These concepts derive from interrelated, overlapping, and often identical data explaining any number of factors which ultimately initiate and sustain the deterioration of the peripheral circulation. It becomes reasonable to assume that the response to stress involves not one but many homeostatic systems. The syndrome most likely develops differently under different circumstances and in different species. This infers that various homeostatic systems may become involved selectively in different sequence or to different degrees. Therefore, the relative importance of any individual deleterious factor must be evaluated in terms of the given set of circumstances being dealt with. The precise experimental use of protective procedures has emphasized the necessity for such evaluation because they clearly demonstrate that no one concept of shock represents the entire pattern of the disturbance.

Just as the response to stress involves different homeostatic systems, experimental procedures which increase tolerance to stress most likely involve different pathways of effect. Each of these procedures seemingly modifies both the vascular and metabolic components of the reaction to injury. In a broad sense almost all protective modalities are characterized by being adaptive proc-

CROSS TOLERANCE TO VARIOUS METHODS OF PROTECTION

AGAINST SHOCK *

	Type of Experimental Shock			
Method of Protection	Drum Trauma	Hemorrhage	Endotoxemia	Gut Ischemia
Drum Training	+ +	+	±	+
Antibiotics	+	+ +	0	+
Endotoxin Tolerance	+ +	+ +	+ +	+
Retic-Endothel. Stim.	+	+	±	unk
Amine Depletion	+ +	+ +	+	unk
Dibenzyline	+ +	+ +	±	+ +

* Based on data for rat, dog or rabbit reported by various investigators

+ = protection, 0 = no protection, ± = inconsistent protection,

unk = data unknown

Fig. 2—The tabulation of cross tolerance is based on data reported by various authors for the rat, dog or rabbit. No inferences are intended for protective procedures or types of experimental shock not listed.

esses at some known or inferred physiologic or metabolic level. This adaptation is initiated by subjecting the animal to one or more episodes of sublethal noxious stimuli prior to the challenge with a normally lethal stress. It is the specificity of such desirable adaptation in terms of site of action and particular mechanisms involved which the different methods of protection can help identify. For instance protective technics demonstrate that each tolerant state has specific attributes not always present in other tolerant states. This is readily apparent if cross tolerance to several types of shock is tabulated (fig. 2) against various methods of protection. More particularly, however, this tabulation suggests two significant features of effective adaptation. The first is that protection will be broader, in terms of types of stress, when more processes of adaptation are stimulated. Dibenzyline, which provides the widest protective effects, modifies the response to many deleterious factors possibly at several physiologic levels. A second feature suggested by a tabulation of cross tolerance is that by blunting the peripheral response to catechol amines such as epinephrine, by whatever means, affords a wide degree of protection. The implication being that an untoward response to epinephrine may represent something akin to a final common pathway of a number of shock-producing stimuli. Protective technics in permitting the experimental interplay of favorable and unfavorable factors is perhaps bringing together the many seemingly unrelated elements which can participate in the response to stress by establishing a relationship among them. By and large it would seem that the irreversible sequelae of shock stem from the impairment of local defense mechanisms particularly in tissues such as the liver and bowel. Protective modalities by one property or another avert this peripheral tissue impairment by preventing the genesis of deleterious situations or by modifying the normal response to such situations.

Summary and Conclusions

Six representative experimental methods of increasing the resistance of laboratory animals to several common types of shock are briefly discussed. These protective technics indicate that a variety of pathways are probably involved in the genesis of factors which lead to irreversibility. Such studies with protective modalities also direct attention to the importance of the reticuloendothelial system, catechol amines, and local bacterial defense mechanisms in determining the nature of the response to stress. Such data emphasize that no single broad concept of the pathogenesis of shock can, at present, be considered a complete and valid entity.

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American Board of Obstetrics and Gynecology

The next scheduled examinations (Part II), oral and clinical, for all candidates, will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from April 11 through 16, 1960. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

Current Bulletins of the American Board of Obstetrics and Gynecology, outlining the requirements for application, may be obtained by writing to the Secretary: Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

Methohexital Sodium: A New Ultrashort-Acting Oxygen Barbiturate for Intravenous Anesthesia*

By V. K. STOELTING, M. D.**

Indianapolis, Indiana

THE FIRST BARBITURATE was introduced in medicine in 1903. Up to the present time, over 2,500 barbiturates have been synthesized with approximately 50 in clinical use today. The fact that they are so widely synthesized attests to their efficacy, but the continual introduction of new ones indicates that more ideal barbiturates are being sought.

The derivatives of urea comprise a number of central nervous system depressants, although urea itself has no depressant properties. Substitution on one of the nitrogen atoms produces a monoureide, and a diureide is formed when substitution is produced on both nitrogen atoms. Barbiturates are diureides formed from condensation of malonic acid and urea. The resulting compound is a ring structure and is referred to as barbituric acid. The enol form is in equilibrium with the keto form which furnishes the hydrogen ion. Sodium salt is produced by the replacement of this hydrogen ion with sodium. This is the most common form of barbiturate as marketed today. No hypnotic properties are obtained until hydrogens in the 5 position are substituted with alkyl or aryl groups. An increase in length of one or both alkyl side chain results in enhanced potency and diminished duration of depression. If these radicals contain over 5 to 6 carbon atoms, hypnotic potency decreases and convulsant properties may appear.

Most of the barbiturates in use contain one short alkyl radical and one of higher molecular weight. An entirely new series of barbiturates has been obtained by substitution of sulfur for oxygen on the urea carbon. These compounds which result from the condensation of thiourea and malonic acid are known as thiobarbiturates. These drugs have a sulfa attached to the second carbon.[1]

Methohexital has an oxygen attached to the second carbon. In this respect, methohexital resembles pentobarbital and secobarbital, the oxygen analogues of thiopental and thiamylal. Hexobarbital (Evipal), the first ultrashort-acting barbiturate used extensively in clinical practice, is also an oxygen barbiturate. It differs chemically from methohexital by the presence of a cyclohexenyl and a methyl group attached to the 5 carbon.

The chemical name of methohexital is alpha dl 1 methyl-5 allyl-5 (1 methyl-2 pentyl) barbituric acid sodium.

The drug is stable in aqueous solution at room temperature (25° C.) for at least six weeks. The pH of such solutions, as with other barbiturate sodium salts, is approximately 11.0. The sodium salt is rapidly and easily soluble in distilled water and saline, producing a clear mixture.

A comparison of methohexital sodium with thiopentobarbital was made in rats, mice, rabbits, monkeys, and dogs. This study showed methohexital sodium to be three times as potent, one and one half times as long in action, and much less likely to show accumulation. The drug did not produce a venous irritation or hemolysis of blood in any of these investigative studies.[2,3,4,5]

Present Study

The average age of 6,500 patients observed in this study was 40 years, with a range from 6 months to 93 years. The average weight was 139 pounds with a range of 18 to 375 pounds. The average anesthesia time was 109 minutes with a range of 10 to 540 minutes.

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Selection of patients was made only with reference to ordinary precautions taken in the use of any barbiturate. All surgical specialties were represented in this study.

Premedication consisted of an appropriate dose of morphine sulfate or meperidine hydrochloride, and atropine sulfate or scopolamine hydrobromide. These drugs were administered 1 to 1½ hours prior to induction of anesthesia.

Technique of Administration

Methohexital sodium was administered intravenously as a 1% solution by intermittent injection, or as a 0.1% or 0.2% solution by continuous drip infusion. The 1% solution was prepared by the addition of 50 ml. of distilled water or normal saline to 500 mg. of methohexital sodium. The 0.1% and 0.2% solutions were obtained by dissolving 500 mg. or 1,000 mg. of methohexital sodium, respectively in 500 ml. of 5% dextrose in distilled water.[2]

The induction of anesthesia was accomplished by the administration of quantities of the drug sufficient to obtund or eliminate the lid reflex. Inhalation agents of nitrous oxide, cyclopropane, ether, or halothane were then administered by the carbon dioxide absorption closed or semi closed, and to and fro or circle filter technique.

Endotracheal intubations were performed with methohexital sodium and succinylcholine administered intravenously from separate syringes. Succinylcholine was given to insure adequate relaxation of the mandibular and pharyngeal muscles.

In all operations requiring muscular relaxation, dimethyltubocurarine iodide or succinylcholine was administered intravenously.

Clinical Results

The induction of anesthesia was rapid and complete in all patients. The amount of drug required for induction averaged 70 mg. and ranged from 20 to 250 mg. Undesirable side effects such as hiccoughing, muscular twitching, apnea, and circulatory depression were noted in many patients. These undesirable effects were closely related to the rapidity of injection and to the amount of drug given at each injection. Patients receiving adequate hypnotic doses of methohexital sodium injected intravenously over a 60 to 90-second interval seldom presented any of these untoward effects.

Patients inadequately premedicated frequently developed hiccoughing or mild muscular twitching.

Hiccoughing occurred in 126 patients. These patients had not been adequately premedicated prior to surgery. Patients adequately sedated preoperatively did not exhibit this undesirable side effect. The hiccoughing was not always relieved by additional amounts of methohexital sodium. This condition frequently persisted until anesthesia was established with other agents such as cyclopropane, ether, or halothane. The administration of curare preparations also controlled the hiccoughing. However as soon as the action of this drug subsided, hiccoughing returned unless anesthesia was established with other agents as previously mentioned.

Muscular twitching was observed in 139 patients. These muscular movements were of a fine tremor, generalized over the entire body but did not become convulsive in nature. Patients presenting this complication were classified as not being properly sedated preoperatively. Additional amounts of methohexital controlled these muscular movements. Deepening the anesthesia with other drugs such as ether, cyclopropane, and halothane also stopped all of these movements.

Respiratory depression frequently followed the initial dose of methohexital sodium. Apnea occurred in 959 patients. This apnea was transient, lasting up to 3 minutes. Intermittent positive pressure ventilation was required during this period. When the patient was markedly depressed by the narcotic used for premedication, or when the drug was injected very rapidly, apnea occurred with great frequency. This initial respiratory depression subsided rapidly permitting spontaneous respiration to be established during the induction with the inhalation agents.

Sixty per cent of the patients complained of pain at the site of injection or along the course of the vein. The intensity of the pain varied, but it usually evoked a spontaneous complaint from the patient. A reassurance that the pain would subside rapidly was sufficient to calm the patient, who lost consciousness within a few seconds. Except for a few patients, who required large amounts of the drug to induce unconsciousness, the patients did not recall the pain when questioned during the postoperative period. None

of the patients developed thrombophlebitis during the postoperative period.

A fall in blood pressure was observed in 678 patients following the administration of the initial dose of methohexital sodium. The systolic pressure was depressed an average of 20 mm. Hg. There was no period of severe hypotension in any patient receiving the drug, which did not respond to vasopressor drugs administered intravenously. Mild depressions in blood pressure returned to normal within a 5-minute period without specific treatment.

Bronchospasm was not observed to occur in any of the patients receiving methohexital sodium. The drug was given to 55 patients with a definite history of asthma. None of these patients showed any clinical evidence of sneezing or bronchoconstriction.

Laryngospasm was an infrequent complication occurring in only 43 patients. It was usually mild and could be relieved by deepening the level of anesthesia and removing the exciting stimulus.

The maintenance of anesthesia, using methohexital sodium in combination with nitrous oxide and oxygen, was more satisfactory when the drug was used by continuous drip infusion. The very short duration of action of the drug necessitated very frequent injections when administered intermittently and the continuous drip technique was found to be more ideal for a level maintenance of hypnosis.

The drug was an ideal preparation for rapid induction of hypnosis when inhalation anesthesia of cyclopropane, ether, or halothane were anticipated. The drug was so rapidly metabolized that it did not interfere with the use of these inhalation agents.

All patients exhibited active reflexes in the operating room at the termination of the surgical procedure. The majority of the patients were oriented and mentally clear even when the drug was given over prolonged periods. A great majority of the patients retched, with or without nausea and emesis, at the termination of anesthesia while still in the operating room. This was not considered to be an unusual or serious complication following inhalation techniques and agents. During the postoperative period all patients remained awake and in full possession of their reflexes.

Three hundred and seventy six patients vomited once or twice during the first 24 hours after the operation. Many of these patients were receiving opiates for relief of pain, and it was felt that this was a contributing factor.

Discussion

For the purpose of comparison, the records of patients who had been given thiopental (pentothal) sodium and thiamylal (surital) sodium with 75 per cent nitrous oxide and 25 per cent oxygen were selected at random from the files of this Department of Anesthesiology and examined. Although the anesthetics were given during previous years, it was felt that the three groups of patients were generally comparable. From this comparison, the mean dose for induction with methohexital sodium is approximately three times as potent as pentothal sodium and four and one half times as potent as surital sodium. Methohexital was utilized about three times as rapidly as pentothal sodium. This is in keeping with the clinical impression that recovery is more rapid following the use of methohexital sodium.

To maintain anesthesia, three times as many milligrams of surital sodium as of the other two drugs were used per hour. Since one and one half times as much surital sodium as pentothal sodium was used for induction, the activity of surital sodium was lost approximately twice as rapidly as that of pentothal sodium.

Gram for gram, methohexital sodium was about four times as potent as surital sodium. Surital sodium was utilized to maintain anesthesia two and one half times as rapidly as methohexital sodium. In terms of anesthetic doses, methohexital sodium was utilized one and one half times as rapidly as surital sodium. This supports the clinical impression that patients recover more promptly after the use of methohexital sodium than after the use of pentothal sodium and surital sodium.

From electroencephalographic tracing, it can be assumed that methohexital sodium acts in a similar but not identical fashion to other hypnotic barbiturates. Many feel that barbiturates owe their depressant action to the ability to inhibit the action of lactic acid dehydrogenase. This does not prevent access of oxygen to the brain cells but produces changes in the electrical impedance of cell walls, cellular metabolism, and changes in frequency in the electroencephalogram. Therefore, it may be that the action of

methohexital sodium is due to an alteration of cellular impedance.

Conclusion

Methohexital sodium can be used safely as an intravenous agent by rapid administration of a single dose, by intermittent administration of successive doses, or by continuous administration of a dilute solution.

The drug is three to six times as potent as pentothal sodium or surital sodium.

Methohexital is more rapidly metabolized in the body than pentothal sodium or surital sodium. Recovery following cessation of anesthesia was prompt with methohexital sodium.

Apnea appears to be the most common finding during induction with methohexital sodium. The margin between adequate respiratory exchange and apnea was very narrow. This period of respiratory depression was of short duration and required manual compression of the rebreathing bag for only a few minutes.

Circulatory depression was not of any serious effect in any of the patients in this study.

Shivering, twitching, and hiccups were more frequent with methohexital sodium than with the thiobarbiturates. These symptoms were not sufficiently severe to be alarming or dangerous.

The incidence of retching, with or without nausea and emesis, was slight and could not be directly attributed to the drug.

Methohexital sodium has been found to be a very useful and safe drug for intravenous administration.

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Immunization Information for International Travel

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Sponsored by Section on Pathology
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CLINICOPATHOLOGIC CONFERENCE

Guest Editor: WILLIAM G. RICHARDS, M. D.
Beaver Dam, Wisconsin

CASE PRESENTATION*

A 43-year-old white male was first admitted to Waupun Memorial Hospital in May, 1957, with the chief complaint of pain and swelling in his legs. The patient had a recurrence of varicose ulcers of both legs. Approximately two months before this admission he had Unna paste boots applied. On removal of the last boots a series of small ulcers were found at the edge of the discolored areas of skin. The patient entered the hospital for treatment of the ulcers.

Past Medical History: He had the usual childhood diseases. At the age of 20 he had a bilateral lobar pneumonia and a thrombophlebitis of both legs. He had ligations of varicose veins in the lower extremities two times, once 15 years ago and once 12 years ago. Since that time he had many injections and Unna paste boot applications for the treatment of varicose veins.

Family History: His father died of pneumonia. His mother died of nephritis.

Physical Examination: His temperature was 98.2 F.; pulse, 84 per minute; respiratory rate, 20 per minute; and blood pressure, 126/70. The skin was clear, warm and dry. Nevi were noted on the left cheek and the nose. The eyes were normal. There was an upper compensated edentulism but the lower teeth were in fair condition. The tongue was normal and there was a moderate chronic tonsillitis. There was no cervical adenopathy and the thyroid gland was normal. The thorax was symmetrical. Breath sounds were somewhat vesicular but no rales were heard. The heart was not enlarged and the tones were regular and of good quality. No murmurs were noted. The abdomen was rounded, no scars were present and there was no tenderness. No palpable masses were noted. The genitourinary system was normal; no herniae were present. The extremities showed the main clinical findings. There was a marked edema of both legs. There was discoloration of both ankles and lower legs with several varicose ulcers present. Scars were noted on the thighs and in the groin from previous vein ligations. The central nervous system showed no abnormalities. The reflexes were physiologic.

Laboratory Examinations: The hemogram on May 14, 1957, showed 15.6 gm. of hemoglobin and a white blood cell count of 7,200/cu. mm. The differential was normal. The urinalysis was also normal. The hematocrit was 48%. A culture of a varicose ulcer of the leg showed no organisms on a gram stained direct smear. Culture, using tryptose phosphate broth, revealed a moderate growth in 24 hours. The gram stain of this culture revealed a gram-negative bacillus with bipolar staining. The sensitivity tests showed sensitivity to streptomycin and chloramphenicol. The organism was resistant to penicillin, erythromycin, chlortetracycline, and oxytetracycline.

On May 24, 1957, a modified Unna paste dressing with elastoplast was applied to the lower extremities. The ulcers were improved but not healed. A nitrofurazone (Furacin) solution dressing was used. The patient received streptomycin 0.5 gm. daily for four days. On May 28, 1957, the patient was discharged.

Final Admission: In September, 1957, the patient entered the hospital with a chief complaint of diarrhea which began three days before admission. The diarrhea was followed by vomiting and generalized abdominal pain. His temperature at that time was 98.6 F. and his pulse rate was 72 per minute. There was no cough or sore throat and no urinary frequency. There was some generalized abdominal tenderness which was somewhat greater in both lower quadrants. However, there was no rigidity or rebound spasm present. Borborygmi were prominent throughout the abdomen. A tentative diag-

* From Waupun Memorial Hospital, Waupun, Wisconsin.

nosis of intestinal flu was made and a paragoric-bismuth compound was ordered. During the 24 hours prior to admission, there was an increase in the intensity of the pain which was still generalized. The diarrhea had ceased but vomiting continued and the vomitus had a dark brown appearance. The patient described it as having a "tobacco juice" appearance. On the night before admission to the hospital the pain was so severe that the patient required sedation for relief in the early morning hours. There was only temporary relief for approximately 3 hours, and on the morning of admission the pain was again severe and continuous. There was still no localization. The admission temperature was 98.6 F. and the pulse was 84 per minute. There was some evidence of dehydration, and it was thought at this time that the patient had an intestinal obstruction. On the day after admission there was no change in his condition.

X-ray examination of the lower intestinal tract showed no intrinsic or extrinsic involvement of the colon or terminal ileum. The x-ray examination of the abdomen and chest, on admission, showed no evidence of obstruction. There was a small amount of gas within the bowel and within the stomach. There was no evidence of abnormal calcification and no evidence of free intraperitoneal air. The leaves of the diaphragm were smooth. The lung fields were clear and the heart and great vessels were normal, as was the rib cage.

On September 19, a second examination of the chest and abdomen revealed a moderate amount of gas within the transverse colon and descending colon but no evidence of obstruction. There were only minimal amounts of gas within the small bowel. There was still no evidence of free intraperitoneal air. It was decided that if an obstruction were present it must be high in the gastrointestinal tract. The patient still had no fever. The abdomen was still soft but very few borborygmi were heard. There was no distention and no localized tenderness or guarding. The possibility of perforation, or perforating peptic ulcer, involving the pancreas was entertained.

On September 20, the patient's wife offered the following information: Approximately three weeks before admission the patient saw a homeopath in regard to his varicose ulcers of the legs. The homeopath proceeded to read a list of symptoms to him from a book; and when he found one which suited the patient, he wrote a name of a drug on a piece of paper. This list came to six different preparations. He gave the patient the list and told him where to obtain the drugs and instructed the patient to take three tablets every hour while awake, starting with the first bottle and taking two of each kind. These instructions the patient had followed religiously for the past two weeks prior to admission. Five labeled bottles of pills were presented by the wife and a sixth without a label. The labeled bottles gave the following information as to content: Ferrum Phosphate, Potassium Chloride, Silica, Calcium Sulphate, and Calcium Fluoride.

Late in the day on September 20, the patient's temperature fell below normal. His pulse was 140 per minute and his respirations were very irregular. His eyes were described as "rolling in their sockets." The skin was clammy and the blood pressure fell to 90/0. On examination of the abdomen, there was an impression of a mass or increased resistance in the left lower quadrant. The patient was very seriously ill. It was decided that a surgical exploration offered his only hope for improvement.

This grave situation was explained to his wife and she agreed that surgery should be attempted. The patient was taken to surgery where, under cyclopropane, oxygen, helium, and ether anesthesia, an exploratory laparotomy was performed. The abdomen was opened through a left parumbilical incision; and immediately upon opening the peritoneal cavity, a large amount of serosanguineous fluid was encountered. This was partially removed with suction, and exploration revealed an interference with the circulation in a large segment of the small intestine. A portion of the bowel, which was in very poor condition, was delivered into the wound and followed distally and proximally to a point where the bowel became relatively normal in appearance. The intestine lying between these two points in the mesentery was clamped and later ligated. An end-to-end anastamosis was done in the usual two-layer manner, and the mesentery was closed. The patient was in very poor condition throughout the entire procedure and left the operating room in poor condition.

The surgical specimen consisted of a segment of jejunum which showed a marked

edema and increased consistency of the wall with an intense reddish purple discoloration of the entire segment of bowel and an increased consistency of the surrounding mesentery.

Postoperatively the patient's temperature rose to 104.4 F. rectally. His blood pressure remained very low and his pulse rate was rapid at 134 per minute. His breathing became very labored and at 6:35 p.m. on September 20, 1957, the patient expired.

Discussion

Dr. Leonard Schrank: This is a case of a 43-year-old white male who had been hospitalized twice within a relatively short period of time; once in May with varicose veins and a history of poor circulation of the lower extremities, and the second time in September with a provisional diagnosis of gastroenteritis and later on of bowel obstruction. Superficially the two appeared unrelated, however, on closer scrutiny, and especially in view of the findings at the time of surgery, there may be some definite relationship between the two pathologic entities. Considering the symptoms that this patient presented prior to his last admission, the provisional diagnosis of intestinal flu was certainly logical. Since the usual therapy was ineffective and the patient's condition deteriorated, it became obvious that this was a more serious illness.

We are confronted with a differential diagnosis of an abdominal disorder. This man's illness began three days prior to admission with diarrhea, vomiting, and generalized abdominal pain. There was no fever, the pulse was 72 per minute. The patient stated that his vomiting was rather forceful. On abdominal examination borborygmi were prominent. The pain became more intense and the diarrhea ceased. Vomiting continued in spite of treatment and was described as dark brown, like tobacco juice.

On admission the symptoms were essentially the same except that the pain was not relieved by morphine. Borborygmi were still present and the pulse was 84 per minute. There was some evidence of dehydration and electrolyte imbalance. A diagnosis of intestinal obstruction of undetermined etiology was made.

I wonder if we could get a little information as to what type of man he was; whether he was large or small or whether he had lost a lot of weight recently?

Dr. L. E. Friedrich: He weighed nearly 300 pounds but was not too obese. He was well over 6 feet tall; a very large individual. He drove a truck and did quite heavy work. He had lost no weight and was doing quite well until the diarrhea and vomiting began.

Dr. Leonard Schrank: The symptoms and signs would indicate that he had an upper bowel obstruction. The problem in my mind is whether it was a mechanical or a paralytic type. Could we see the x-rays that were taken?

Dr. H. G. Bayley (Radiologist): The film of the abdomen on the morning after admission showed nothing abnormal. There was no free air in the peritoneal cavity. There were no calcifications and no signs of a bowel obstruction. Films taken later the same day showed a little gas scattered throughout the colon and a little gas in the stomach.

Films of the abdomen taken one day later showed no abnormalities in the colon; no signs of irritability; no signs of abnormal dilatation and no sign of any bowel obstruction in the large bowel or in the region of the terminal ileum. The evacuation film showed that he did not evacuate very well but that is not too unusual.

Dr. Leonard Schrank: Because of the presence of the borborygmi without a great deal of distention and then in the absence of the fever, one can assume that the obstruction was not due to an infection such as a peritonitis resulting from a perforation of an organ. The dark, coffee-brown emesis indicated that the obstruction was more likely to be in the upper part of the intestinal tract. In the absence of the typical x-ray findings and the absence of fecal vomiting, one can then assume that the obstruction was very high. The obstruction may have been on a paralytic basis such as in thrombosis or hemorrhage, although one cannot be certain of ruling out mechanical obstruction. In any event, the patient became almost moribund; and it was obvious that if treatment were to save this man, it would have to be something of a very heroic nature.

This patient had been taking a variety of drugs, prescribed by a homeopath, for his leg ulcers. It would be interesting to know the dosages of the various tablets, precisely, so that we could determine whether or not any of these could have been in toxic amounts.

I have been told that homeopaths deal in small dosages; at least when I give a small

dose, I am accused of being a homeopath. If the doses were not any larger than reported, I think that they were probably innoxious. Fluorides digested in large amounts can cause abdominal pain and severe vomiting.

Surgery revealed what was apparently a mesenteric thrombosis with a gangrenous jejunum. The diagnosis then would be bowel obstruction of a paralytic type due to mesenteric thrombosis. According to the history, the patient had been admitted previously with varicose ulcers. With this fact in mind, the possibility of an embolic episode must be considered. If he did have a migrating type of thrombosis that radiated into the large vessels, it would have to travel a considerable way. A thrombosis in the lower extremities that had split off and formed an embolus would have to go through the lung first before it could reach the circulation of the smaller bowel. Are there any comments before I summarize?

Dr. W. A. Wagner: Did the section of bowel removed show an arterial mesenteric thrombosis, or was it a passive congestion?

Dr. C. P. Reslock: The loop of bowel that was removed was typical of venous thrombosis rather than arterial.

Dr. M. F. Ries: There were no signs of this being a torsion rather than a thrombosis?

Dr. C. P. Reslock: No.

Dr. J. A. Peterson: What would you consider the reason for his varicosities?

Dr. C. P. Reslock: The history of leg ulcers dated from his youth. At age 12 he had pneumonia, and leg ulcers developed subsequently. Because he had his pneumonia before the advent of antibiotics, he was in bed for a considerable time. Thrombophlebitis was presumed to have been the original cause of his leg ulcers.

Dr. W. J. Petters: The facts in the case have been pretty well covered, but I would like to discuss the differential diagnosis. Just prior to surgery the patient had a vague mass palpable in the left side of the abdomen in the left lower quadrant. In mesenteric thromboses this is a finding that is occasionally noted. When present it is apparently due to the intestine involved in the thrombosis. In reference to the two-week period during which the patient was taking the minerals ordered by the homeopath, I agree that the possibility of this being a cause of his death, or cause of his illness, is rather a remote one. The dosages of homeopathic drugs are so small that probably taking a whole bottle of any one of them would not cause any toxic effect other than a few loose stools. The calcium fluoride could conceivably cause a toxic condition, but the symptoms of fluoride poisoning should be more acute. There is a remote possibility that this man had a retroperitoneal tumor which was involving the vascular supply to the bowel. Another less remote possibility is a cardiac disease with a concurrent vascular disease. This is a very common reason for a sudden mesenteric thrombosis. Pancreatic disease, *i.e.*, sudden pancreatic necrosis, must also be considered. This man had all the symptoms of an acute pancreatic necrosis. He had pain and the vascular shock. The abdominal findings were not characteristic at surgery, but the possibility has to be included in the differential diagnosis. In summing up my differential diagnoses, I would also like to settle on mesenteric thrombosis either (1) on the basis of a cardiovascular disease; (2) secondary to an acute pancreatic necrosis; or (3) of an idiopathic type.

Dr. Raymond Schrank: There is one other possibility which we should include and which has been pretty well excluded by the surgery. There were no signs of a small bowel obstruction prior to the shock, therefore we must consider the possibility of small bowel tumor such as lipoma or adenoma with intussusception causing the shock. We know from the surgery that it was not an intussusception; but with a sudden onset of shock and increasing abdominal pain, he could have had just an intestinal flu with increased peristalsis and then the intussusception causing the shock picture.

Dr. Leonard Schrank: Yes, that is very possible. Are there any other comments?

Dr. D. P. Cupery: We have gone over very briefly the possibility of mechanical obstruction. The possibility of adhesions with volvulous occurs to me. Had this man ever had abdominal surgery of any kind?

Dr. Leonard Schrank: No, and he had no scars on his abdomen. Since the x-rays were of a negative nature, I wonder what help we could expect from the radiologist in the diagnosis of mesenteric thrombosis?

Dr. H. G. Bayley (Radiologist): The findings of mesenteric thrombosis are similar to those of acute pancreatitis in that the films most of the time are negative, but progressive and serial films such as we have are helpful. If we had had a film on the day of surgery, possibly then we would have seen dilatation of localized loops of bowel.

The bowel will respond in three ways as far as what we see on the film. Very often it will show dilatation of the involved segment and that is determined entirely by the blood supply. The less common finding is a spasm or traction of a segment of bowel with dilatation proximal to it. The most common finding is what we have here, that is, a normal appearing abdomen. Now obviously the colon would not show anything because this was small bowel.

Summary

Dr. Leonard Schrank: The facts have all been gathered so I will now summarize. The triad of abdominal pain, early vomiting, and shock would indicate high intestinal obstruction. In the absence of positive x-ray findings and the presence of coffee ground vomitus with no fever or leukocytosis, the etiology of the obstruction resolves itself, in my opinion, to mesenteric venous thrombosis or mesenteric arterial infarction.

It is difficult to differentiate between the two entities clinically, although the history may be of some value. The surgeon has described the vascular obstruction as venous rather than arterial. The possible causes of venous thrombosis in the superior mesenteric vein include (1) inflammation of the bowel or appendix; (2) portal venous obstruction; (3) trauma; and (4) strangulated herniae.

Autopsy Findings

Dr. Wm. G. Richards: This was the body of a well-developed and very well muscled, somewhat obese, white male. He weighed approximately 250 pounds and was 6 feet, 3 inches in height. There were 4.5 to 5 cm. of panniculus adiposa in the anterior abdominal wall.

On external examination the most important finding was the presence of varicose ulcers on the lower extremities. There were old scars from the previous vein ligations and a marked discoloration of the skin. These are typical findings of a long-standing difficulty with venous circulation of the lower extremities. On opening the peritoneal cavity there were approximately 100 to 300 cc. of serosanguineous fluid, and a greater portion of the jejunum and a portion of the ileum showed a reddish purple discoloration. They were swollen and edematous and had a fibrinous exudate on their surfaces. The heart weighed 500 gm. and was dilated. There was a mild atherosclerosis of the ascending aorta. There was a very mild diminution of the lumens of the coronary arteries but no occlusions were present. The heart valves were normal and the musculature was normal. The right lung weighed 600 gm. and the left lung weighed 500 gm. There was a considerable amount of edema present and some patchy atelectasis in the lower lobes. The most important findings were in the gastrointestinal tract. This was examined from midesophagus to rectum. It contained a reddish brown liquid material which resembled partially digested blood. The stomach, duodenum, and first portion of the jejunum were normal. The pathology began at a point approximately one foot from the ligament of Treitz where the mucosa of the jejunum became markedly edematous and had a reddish purple discoloration. The greater portion of the lower jejunum and the first portion of the ileum were involved in the process.

The majority of the ileum had been spared. A thrombus was present in the superior mesenteric vein and this was continuous with a thrombus in the splenic vein and the portal vein. The thrombus extended into the hepatic divisions of the portal vein and extended backward throughout the portal vein to the tributaries of the portal vein, the lienal, or splenic vein, and the superior mesenteric vein. The splenic thrombus extended along the splenic vein right up to the hilus of the spleen and into some of the ramifications of the splenic vein within the spleen. The spleen was infarcted. It weighed 400 gm. The thrombus also extended for some distance down the major tributary from the upper bowel. The liver showed mild nutmegging and weighed 2,380 gm. It had a yellowish tan anemic appearance and was quite friable. The common iliac veins were also examined but no thrombi were present in any of the veins lower than the superior mesenteric vein. The most important findings microscopically were in the portal vein. The portal vein showed fragmentation of the fibers in the intima, subintima, and the media. There was a fibrous connective tissue hyperplasia

throughout the media of the vessel so that nodules were formed within the lumen of the portal vein and the typical microscopic findings of phlebosclerosis were noted. The cause of death was attributed to a combination of portal, splenic, and superior mesenteric vein thrombosis.

Portal vein thrombosis usually starts at four main points: at the tributary to the intestinal vessels, in the main stem of the portal vein, in the splenic vein, or in the hepatic branches of the portal vein. If the condition develops rapidly, the patient dies of an acute portal hypertension and small bowel infarction. The lesion is usually associated with mesenteric thrombosis which accounts for the acutely fatal mesenteric congestion. This patient's symptoms were characteristic of a portal vein thrombosis with superior mesenteric venous thrombosis. The causes of portal vein thrombosis include: (1) spontaneous clotting following splenectomy or progression of a splenic vein thrombosis; (2) complication in hepatic cirrhosis; (3) complicating appendicitis, cholecystitis, pancreatitis, or cholangitis; (4) compression of the vein by neoplasm or trauma; and (5) primary phlebosclerotic changes in the vessel wall comparable to arteriosclerosis. The phlebosclerotic changes in the portal vein may account for the portal thrombosis.

There is an entity known as "migrating venous thrombosis" which is seen predominantly in young males and is characterized by repeated attacks of thrombosis with months or years between attacks. It begins in the deep veins of the legs early in life and eventually the abdominal veins, and terminally the portal vein may be involved. The changes are those of phlebosclerosis and are identical with those of thrombophlebitis minus the inflammation.

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Facts on Alcoholism in Wisconsin 1957–1958

By WILLIAM F. STEWART*

Madison, Wisconsin

THE EXTENT and seriousness of alcoholism as a public health problem is often underestimated because of the lack of readily available data on the subject. This is due primarily to public attitudes toward overindulgence in beverage alcohol, which prevent any direct method of measurement. While hospital admissions, arrests for drunkenness, or deaths due to alcoholism indicate certain areas of the problem, they cannot reveal the total situation.

An ingenious method of indirectly estimating the number of alcoholics, developed by E. M. Jellinek, is receiving greater attention in this country and elsewhere, however. (For a description of this method and a critical evaluation, see the article by R. E. Popham.[1]) Briefly, his method depends on an observed relationship between the percentages of alcoholics who die of cirrhosis of the liver and the proportion of all deaths from cirrhosis that are attributable to alcoholism.

When the Jellinek formula is applied to Wisconsin data on deaths from cirrhosis, we obtain the following estimates:

TABLE 1—NUMBER AND RATE PER 100,000 OF ALCOHOLICS IN WISCONSIN, 1949–1958, BY SEX*
(Based on the Jellinek formula)

3-Year Periods	Male		Female		Total	
	No.	Rate	No.	Rate	No.	Rate
1949–1951	60,450	5,431	10,960	962	71,410	3,170
1951–1953	65,880	5,859	11,580	996	77,460	3,420
1953–1955	74,450	6,549	11,860	1,002	86,310	3,720
1955–1957	88,430	7,685	11,700	971	100,130	4,250
1956–1958	91,210	7,880	12,980	1,067	104,190	4,388
Per Cent Increase in Rate 1950–1957		45.1%		10.9%		38.4%

*Rates based on the adult population, aged 20 years and over.

According to these estimates, Wisconsin has over 100,000 alcoholics at the present time, whereas their number and rate has been increasing sharply since 1950. We also find that in the last 8 years the Wisconsin rate of alcoholism has increased 38%. Contrary to popular opinion, the number of female alcoholics has *not* been increasing faster than their male counterparts. While the male rate has climbed 45% in the last 8 years, the female rate has a gain of only 11% for the same period. The current sex ratio would be approximately 7 male alcoholics for every 1 female.

The seriousness of the problem is shown by the 121 known deaths attributable to chronic alcoholism in 1958 and 144 in 1957. Because of the small number of cases in certain segments of the population, these two years, 1957 and 1958, have been combined to remove some of the chance variations in table 2 on the following page.

Table 2 strikingly reveals the familiar pattern of a short life span for those afflicted with this illness; of all the persons who die from chronic alcoholism, a very large proportion of them, 54.9%, are between the ages of 40 and 59. This compares with the 15.4% of all deaths in this age group.

The fact that over three-fourths of all persons dying from alcoholism are males (78.1%) comes as no surprise to those familiar with the problem.

The inadequacy of mortality statistics in measuring alcoholism can be seen by noting that the percentage of male cirrhosis of liver deaths attributed to alcoholism is only 26.0% for the two years. If we accept Jellinek's estimate, based on clinical observation, of 62.8% of the liver cirrhosis deaths due to alcoholism, an additional 187 male deaths should have been reported for this period. Surprisingly, the corresponding figure reported for Wisconsin females—20.9%—is remarkably close to the 21.6% estimated by Jellinek. Since very few female deaths seem to be missing, we can estimate the total deaths due to alcoholism for 1957–1958 at approximately 450, or 225 per year.

Regarding marital status, it appears that a woman who succumbs to alcoholism is more apt to remain part of a family group

* Director of Statistical Services, Wisconsin State Board of Health's Bureau of Vital Statistics.

TABLE 2—NUMBER AND PER CENT OF RESIDENT DEATHS DUE TO ALCOHOLISM, BY AGE AND SEX
WISCONSIN—1957 AND 1958 COMBINED

Cause of Death	I.C.D. Number	Total		Age Groups													
				Under 20		20–29		30–39		40–49		50–59		60–69		70+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Accidental Poisoning (Alcohol)	880	6				3		1		1						1	
Accidental Poisoning (Barbiturate)	871	3	1							2			1	1			
Alcoholic Psychoses	307	12	3					2		1	3	6		2		1	
Acute Pancreatitis	587	3	1							2	1	1					
Alcoholism	322	46	8	1				4	3	12	3	11		14	2	4	
Cirrhosis of Liver (With Alcohol)	581	132	43					10	4	27	15	42	14	36	7	16	3
All Others*		5	2			1		1			2	1		1		1	
Total		207	58	1		4		18	7	45	24	61	15	54	9	23	3
Per Cent of Total		100.0		0.4		1.5		9.5		26.1		28.8		23.9		9.8	

*All others includes (2) from Excessive Cold (932), and one each of the following: Other Diseases of the Liver (583); Epilepsy (353); Other Avitaminoses and Nutritional Deficiency States (286); Accidental Poisoning by Other Analgesic and Soporific Drugs (Paraldehyde) (874); Suicide and Self-Inflicted Poisoning (Methyl Alcohol) (971).

(Special notice should be paid to the fact that when "Laennec's cirrhosis" is given as the underlying cause of death by the attending physician on the death certificate, then the death is automatically coded to cirrhosis of liver with alcoholism according to the International Classification of Diseases categories.)

than is the case for males. The percentage of females reported as married at the time of death was 71% compared to 44% for the males. Eighteen per cent of the men were divorced, in contrast to only 4% for the women.

Our statistics do not show any apparent disproportion among the races, when compared to the population, for those who die of the effects of chronic alcoholism. Of course, the small percentage of nonwhite persons in this state would require observation over a long period of years to determine statistically significant differences.

In keeping with the progressive nature of this illness, we find in table 3 that the age-specific death rate increases in the older years up to the point where degenerative processes take their toll.

TABLE 3—AGE-SPECIFIC MORTALITY RATES FOR DEATHS DUE TO CHRONIC ALCOHOLISM
WISCONSIN 1957–1958

(Rates per 100,000 population)

Age Groups	Under 20	20–29	30–39	40–49	50–59	60–69	70+	Total
Rate	0.3	0.4	2.4	7.2	9.6	10.1	5.8	3.4

A breakdown of the occupations reported on death certificates indicates an under-representation of upper socio-economic groups, but this data is difficult to evaluate. For one thing, there is the problem of the loss of usual occupation as the illness progresses.

One bit of occupational information of particular interest is the fact that relatively large numbers of these persons work in occupations involving alcoholic beverages. The percentage of all alcoholic deaths represented by these occupations was 12. 1, or 32 persons in two years. Their specific jobs were as follows:

Tavern owners or keepers	21
Bartenders	7
Brewery Employees	4

Note: Since this article was written, three critiques of the Jellinek formula by Seeley, Brenner and Jellinek appeared in the Quarterly Journal of Studies on Alcohol, June, 1959, pp. 245–269.

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COMMENTS ON TREATMENT

Drug Therapy During Cardiac Arrest

By GEORGE G. ROWE, M. D.*
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CARDIAC ARREST IS one of the acute medical emergencies requiring immediate decision and action if effective therapy is to be instituted. When arrest occurs in the operating room, the decision is not difficult, since equipment for surgical intervention and for maintenance of inflation of the lungs is readily available. Furthermore, those patients receiving surgical intervention have been deemed in satisfactory general condition to warrant surgical therapy and, therefore, generally deserve an attempt at resuscitation should cardiac arrest occur. When arrest occurs in subjects outside of the operating room, however, the situation is different. One must decide whether or not the patient has the fundamental health to permit restoration of life; whether adequate equipment is present or available to permit successful resuscitation in the location in which arrest has occurred; and whether, since such subjects commonly have not been under as close observation as the surgical patient, there is any reasonable guarantee that the subject has not already been hypoxic too long for adequate restoration of central nervous system function. There are abundant references in the medical literature indicating that in cardiac arrest of greater duration than 4 minutes, resuscitation is very apt to be unsuccessful; and if it is successful, there is a reasonable chance that irreversible central nervous system damage will have occurred. In some cases brain destruction is so severe as to make continued "life" an intolerable burden.

Whatever preliminary measures are used in an attempt at cardiac resuscitation, such as forceable striking of the chest, needling of the heart with injection of epinephrine and or atropine, or electrical stimulation of the heart, it must be remembered that each additional minute without cardiac action seriously impairs chances of resuscitation and the majority of subjects with cardiac arrest in whom resuscitation has been accomplished have had cardiac massage. It seems certain that drugs injected into peripheral vessels during cardiac arrest prior to the onset of cardiac massage would not be carried through the circulation rapidly enough to be effective, and it is doubtful if drugs administered into the cardiac chambers diffuse sufficiently in the absence of cardiac action to reach a site where they are active. During massage, drugs may be administered effectively into the peripheral vessels, the cardiac chambers, or for maximum cardiac effect the ascending aorta may be clamped with a noncrushing clamp above the origin of the coronary arteries and drugs may be injected into its proximal part so that massage forces them directly into the coronary circulation. When adequate ventilation of the lungs is established and effective cardiac massage is being performed, the emergency of cardiac arrest is over and one may pause figuratively to chart the course of future action.

If, after a short period of massage, the heart beats well, maintaining a good blood pressure and output, the heroic phase of therapy is over and one would do well to consider the cause of the episode. Any correctable cause of hypoxia must be dealt with effectively. If arrest occurred from a sudden decrease in a high blood concentration of carbon dioxide, more careful and regular ventilation must be done to avoid such sudden changes. If the cause appears to have been an overdose of medication or anesthetic, appropriate counteracting medications may be

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given. Particularly, if the episode was of so-called vasovagal origin, occurring during stimulation of the pharynx, larynx, trachea, bronchi, lung, vagus nerve, or bile ducts, and the operation which precipitated arrest has not been completed, arrest is prone to recur. It may be wise before repeating any manipulation of these structures to administer 0.5 to 1.0 mg.* of atropine in an attempt to prevent recurrence.

On the other hand, if adequate cardiac action is not readily restored, prolonged massage may be required and considerable damage may be done to the heart. After prolonged cardiac massage hemorrhages may be found in the epicardium, myocardium and endocardium, and recently accomplished intracardiac repairs may be disrupted. Under such circumstances it is well to secure complete digitalization; and since immediate effectiveness of therapy is desirable, primary consideration should be given to the more rapidly acting digitalis preparations. Particularly, if the patient has been digitalized previously, one may be inclined to use the very rapid acting drugs, acetylstrophanthidin or ouabain, on the hypothesis that the full effectiveness of the drug will be reached while the heart is still "in the surgeon's hands" and one can take a bolder approach to determine how much digitalis is required. The deficit in the patient's digitalizing program may then be made up by a longer acting drug administered immediately, since it will become effective as the effect of the acetylstrophanthidin or ouabain diminishes. If the patient has not been digitalized previously, one may still use the very rapidly acting drugs, (acetylstrophanthidin 0.5 to 1.2 mg., or ouabain 0.5 to 1.0 mg. intravenously) but a slower acting digitalis preparation (deslanoside 0.8 mg.) may be given intravenously also and increased as required so that digitalization may be maintained in the post-resuscitative period when cardiac insufficiency is prone to occur as a result of myocardial damage from massage.

If the force of cardiac action is insufficient, the heart flabby and failing to beat satisfactorily, administration of calcium salts may be very effective. These may be administered either as the gluconate or chloride (1 to 2 g. intravenously: 4 to 8 ml. of 10% solution into the aorta) and the dose can be adjusted by the response of the myocardium remembering that the total dosage of calcium gluconate must be higher to be equally as effective as the chloride. If administration of calcium is ineffective one may consider administration of molar sodium lactate (40 to 160 ml. intravenously) not only for its effects on the expected systemic and cardiac metabolic acidosis, but also apparently for the nutrient effect of the lactate ion on the myocardium. One must beware of multiple ventricular premature contractions during the administration of molar lactate, attempting to adjust the dose so as to obtain increased force of contraction and increased irritability, without producing too much irritability or administering so much sodium that retention of fluid is a significant problem postoperatively. When decreased cardiac irritability is a problem, one may also consider the administration of epinephrine (0.2 to 0.5 ml. of 1:1000 solution) and on occasion this may be very effective. Such an effect is very transient, however, and repeated doses, or administration of epinephrine in oil (0.5 to 1.0 ml. of 1:500) may be required.

If ventricular fibrillation is present, the heart should be massaged vigorously for several minutes to restore systemic and cardiac oxygenation in the hope that ventricular fibrillation will revert spontaneously to a sinus rhythm. If this does not occur, and particularly if the fibrillation is coarse with very poor myocardial tone and considerable cardiac dilation, it may be wise to administer calcium chloride or epinephrine to improve the tone of the myocardium before defibrillation is attempted. The preferred method of defibrillation is administration of sufficient electrical current through the myocardium to depolarize all of the fibres simultaneously in the hope that when contraction begins again it will begin in an organized fashion with restoration of a normal beat. This current may be administered most safely and efficiently by the various commercial cardiac defibrillators, but any adequate current source, including the standard 110–120 Volt, 60 cycle alternating current which is domestically available, can be successful. With make-shift apparatus using the standard household current, the surgeon must exercise sufficient caution to avoid self electrocution. If electrical defibrillation is not practicable, defibrillation may be accomplished by administering

* All drug dose ranges suggested in this paper are for adults and may need appropriate correction for body size.

10% potassium chloride. The ordinary method of administration is to cross clamp the aorta above the coronary vessels and inject a sufficient quantity of potassium chloride (3 to 8 ml. 10% solution) into the ascending aorta, massaging it through the coronary circulation as it is administered and observing the heart until it becomes flabby, dilates, and fails to contract. As soon as complete arrest has been secured, the aortic clamp is removed and massage is continued in order to remove the excess potassium from the myocardium and reinstitute cardiac action. This method of defibrillation presents the disadvantage that it may be difficult to restore adequate cardiac contraction after potassium arrest. However, if this proves to be the case, the effects of potassium can be neutralized and the myocardial tone improved by administration of calcium chloride.

It is unusual with adequate oxygenation, massage, and drug therapy to fail to establish organized cardiac action. Indeed the human heart has been revived quite consistently after natural death and made to perform adequately as a Starling heart-lung apparatus. However, it is usually difficult to maintain sufficient cardiac output and systemic arterial pressure after an organized beat has been restored, and consequently at the present time only approximately one third of patients with cardiac arrest survive the episode. In the therapy of such "cardiogenic shock" after resuscitation, one may administer levarterenol (*l*-norepinephrine) in a sufficient concentration (4 to 16 mg./l., or more if required) to obtain the desired effect. Levophed® (levarterenol) under these circumstances, appears to be nearly an ideal drug since it increases the venous tone, the force of myocardial contraction, the coronary blood flow and the systemic arterial blood pressure. Since restriction of fluid becomes important in therapy at this point, it is wise to increase the concentration of Levophed®, as required, rather than to increase the rate of administration of the fluid in which the Levophed® is contained. When multiple premature ventricular contractions or other arrhythmias are a problem after resuscitation, one may consider administration of various myocardial depressants such as quinidine (up to 650 mg. intravenously, slowly) procaine amide (up to 1 g., total not exceeding a rate of 100 mg./min.), lidocaine (0.5 to 1.0 mg./kg. intravenously) or procaine. One must remember, however, that the myocardium is already damaged by the episode of arrest and massage, and depression by these drugs may be dangerous; therefore, the blood pressure and electrocardiogram must be watched carefully during their administration.

Once adequate cardiac action is restored and peripheral blood pressure is maintained one must turn his attention to the anticipated difficulties with the brain, the lungs, and the kidneys. If there has been significant hypoxia of the central nervous system, edema of the brain will almost surely occur. In its therapy many advise the use of prolonged hypothermia, and there is general agreement that hyperpyrexia must be avoided. Intravenous administration of hypertonic solutions of glucose (50 ml. of 50% solution) and/or urea (1 g./kg. as 30% solution) produce temporary cerebral dehydration which may tide the patient over the most difficult phase, and the administration of anticonvulsants may be required. The total volume of fluid administered must be kept at a minimum until adequate renal function is assured to avoid both cerebral and pulmonary edema. The latter may require major therapeutic efforts, since both cardiac and renal insufficiency are common in the recovery phase. Should the period of renal hypoxia have been sufficient to produce tubular necrosis one must anticipate effective therapy of oliguria or anuria. Each of these, cerebral damage, pulmonary edema, and renal tubular necrosis, constitutes its own major medical problem, too extensive to consider further here.

In summary, cardiac arrest constitutes an acute emergency generally requiring thoracotomy and cardiac massage. Drug therapy is a secondary but very important consideration once the acute emergency is resolved, with its aims the restoration and maintenance of effective cardiac action and prevention of recurrence of arrest. Survival of many subjects will depend on the postoperative care of central nervous system damage from hypoxia, pulmonary congestion and edema, and renal insufficiency secondary to tubular necrosis.

1300 University Avenue (6).

The President's Page . . .

ANOTHER PROCRUSTES' BED

The question of whether the federal government should provide some type of health insurance for those over age 65 is rapidly assuming importance as a 1960 election issue. The bill attracting the most attention in Congress is H.R. 4700 sponsored by Rep. Aime J. Forand. His bill would again increase social security taxes to extend hospitalization, nursing home care, and surgical service to persons receiving social security benefits.

The Forand bill is supported by such groups as the Americans for Democratic Action, National Farmers Union, AFL–CIO, and the American Nurses Association. It may come as a shock to many physicians that the Wisconsin State Nurses Association just recently added its voice to those favoring this compulsory health insurance program.

Opposition to the Forand bill comes from the American Medical Association, American Dental Association, American Farm Bureau, American Hospital Association, American Nursing Home Association, Chamber of Commerce of the U.S. and the Health Insurance Association of America.

Recently, the *Green Bay Press–Gazette*, has editorialized several times on this topic in an effort to focus attention on the issues. The paper said: "If it really becomes an issue in the upcoming election, everyone will be expected to have an opinion on the proposal if he is to vote intelligently."

I contend that the observation of the *Press–Gazette* might first be heeded by the members of the medical profession. Congressmen will be returning to their work in Washington in January, picking up the Forand bill debate where it left off in Congressional committee.

Physicians must understand, and they must bring about public understanding, that the Forand bill is a form of national compulsory health insurance. True, for the moment, it is limited in scope. But many who have testified so far admittedly seek to extend the idea to every segment of the population.

The arguments against the Forand bill are overwhelming: it does not cover all those who really need help; its cost is $1.1 to $2.3 billion to start, almost unlimited thereafter; free choice under H.R. 4700 is virtually no choice, either to participate or to choose your own health care vendor; voluntary efforts would be discouraged; it is a foot in the door to socialized medicine; quality of care will suffer from abuse, over-use and malingering; and federal support means federal control and regimentation.

I was impressed with the testimony of Frederick C. Swartz, M.D., Lansing, Michigan, Chairman of the AMA Committee on Aging, when he appeared before the House Ways and Means Committee on H.R. 4700:

"If we abandon the community approach in favor of a rigid national health program we will, in effect, have constructed another Procrustes bed. The mythological Procrustes, you will remember, developed a bed that was just the right size for everybody. There was only one trouble with it. Procrustes, instead of altering the bed to fit the person, altered the person to fit the bed. He accomplished this feat of legerdemain by trimming off the legs of the tall, and stretching his shorter victims on the rack."

The needs of the aged are broader than those of health alone. Until society recognizes this it will continue to consider the piecemeal, hit-or-miss political football approaches which attempt to tailor the patient to fit the bed.

Medicine, and its individual members, must speak out firmly, clearly, unequivocally—and now—that this legislation will result in poorer, not better, health care for the people of this country.

William B. Weldenhammer M.D.

Editorial Director
DAVID N. GOLDSTEIN, M. D.

EDITORIALS

The Physician and the Insurance Business

The doctor deceives himself who believes he need not be concerned with the kind of sickness insurance his patients carry. Fifteen years ago, a physician could administer to the purely medical requirements of his patients and be satisfied that he had fulfilled the obligations of his function in society. This is not true today.

The role of the doctor of medicine has been of necessity vastly broadened. Today he must not only minister to the medical needs of his patient, but also he must consider it his duty to protect the personal relationship between his patient and himself in a changed social environment. He is forced to consider the economics of how his patient is going to pay for his services in order to retain control of his own practice.

This situation has been brought about by two important changes in our country during the past decade. In the first place, we have seen what has been described as a population explosion. A census increase of approximately fifty million persons in a matter of 20 years means that the medical need to be satisfied has been enormously expanded. In addition, the lengthened life span and the increased medical service that can be provided have not only further widened the demand for medical care, but also have complicated it to a fantastic degree.

The second important change is that a large proportion of the total population has become accustomed to a higher standard of living than it has ever enjoyed before. Along with the material characteristics of the richer life, these people are demanding—and getting in one way or another—more medical care.

These changes have great significance for the practice of medicine. Despite the quantitative increase for service, the pressure for socialized medicine—except for special sections of the population such as the aged, certain union groups, military personnel and a few others—has been relieved. That is because many more wage-earners can now afford the prepayment plans that assure adequate medical care when it is required. Instead of free medical care, supplied by the government and financed by general taxation, insurance against medical destitution becomes important. And therefore, the insuring agency becomes involved in the relationship between the patient and his doctor.

That is why the doctor can no longer be indifferent to the kind of medical insurance his patients buy; nor can he be unconcerned with the character of the health service available to his patient. If the patient is indemnified in whole or part by an insuring agency beyond the control of the doctor, the doctor–patient relationship must become a doctor–insurer–patient triangle. This intrusion of a third party, in a fiscal capacity, inevitably affects the conduct of the doctor toward his patient, and vice versa, in an adverse manner. Questions of quality and amount of care, as well as value of services, become subject to non-professional and possibly hostile judgment and could lead to medical practices controlled and owned by private organizations.

To protect the traditional, individual relationship between doctor and patient, the doctor must himself keep control over the insuring agency. In the trend toward no-fee-schedule policies rather than partial service benefit or indemnity policies, the doctor may be the only one who can, through existing medical organization, offer a reasonable, low cost policy in a practical efficient manner. At the same time, the doctor, through his organization, can be a major factor in the control of abuse of prepaid medical care plans by policing the extravagance of patients and fellow doctors alike.

By the same token, by leading the way toward planned care for the aged, the medical profession can shut out the intrusion of government agency as well as predatory commercial enterprise in this complicated and vitally important area of medical care. And finally, through its own prepayment plans, the medical profession can assure that the ancillary services continue in their proper relationship to physicians and to each other.

These are the considerations that make it necessary for each doctor of medicine to take a strong positive attitude toward the problems of medical prepayment. Those who believe that the question is not one for the medical profession are living in a by-gone era. The problem is here; the solutions are at hand. It is the responsibility of the physician to see that the problem is solved without detriment to his patient and to himself.

Medical School: Indian Fashion

SECTION ON MEDICAL HISTORY

Like the white man, the Indians of North America held Medicine in the highest esteem. Within the tribes, medicine men formed secret societies to keep the details of their medical treatments from all but a chosen few. They were handed down from generation to generation.

Early accounts of Wisconsin's Winnebagoes report that their treatments of wounds and chronic sores were more successful than those of the average white surgeons. They dressed wounds carefully and applied hot poultices of herbs. For various sicknesses there were concoctions of herbs, roots and barks of trees. "Sweats" and rubbings were recommended.

The bedside manner was enhanced with mystic ceremonials, incantations and singing.

When a medicine man was needed, he was tendered a present in advance, sort of a retaining fee. Many would not respond to a call without such a fee.

But if, in the course of time, the patient did not improve or even died, the medicine man was summarily dismissed from the case. All fees he had received were expected to be given back. A new practitioner was brought in on the same terms: "No cure, no pay."

The Indian medical school, like today, had its fees. When a young brave wanted to join up (and was accepted by the fraternity) he first had to accumulate a heap of goods as an initiation fee. In the days before government subsidies, it sometimes took him years to save up the fee. But then the federal government moved in and made it quite a bit easier.

"Indeed, the demands of the (secret) society swallow up no small portion of the government annuity," says an old account.

The initiation fees were given to the head medicine man of the neighborhood who was supposed to divide them among the close brotherhood. "But it is a matter of general notoriety that he keeps the lion's share." It was also noted that medicine meetings for initiates were craftily planned to coincide with the return home from the visit to the government paymaster.

Sometimes just one novice was initiated at once, sometimes two or three. The medicine meeting would last all day, and often through the succeeding night. Time was no object to the Indian. Meetings were held in a long lodge, 100 feet in length, specially erected for the purpose. The main event was often open to all.

In the midst of all the ceremonies the candidate was led off into the bushes by two or three top medics. What transpired in the bushes is not known, but the candidate came back after ten minutes or so, "pale with fright and much exhausted."

But he had acquired a medicine bag, made from the dried skin of an otter or beaver, with the head and tail preserved, sewed into the form of a pouch. Then there was more talking, dancing, whispering and "jerky movements", and the novice was declared a full-fledged medicine man.

Recognizing that the instruction in the arts of medicine was thus somewhat brief, few among the medicine men ever practiced. Nevertheless they had acquired the right to do so. Actually, it was only those a bit on in years, who had picked up the hang of the business, that did the practicing. And with the "no cure, no pay" basis of treatment, it was not too lucrative a profession.

Occasionally an Indian doctor got employment among the whites. Back in the 1890's a Winnebago woman had a good practice going in Black River Falls. Before that, a "Doc" Decorah of Adams county had had a nice run of patronage in Reedsburg.

But Indian practitioners complained that many of their white brethren were not very good at paying. Indian medicine men were naturally pleased with white patronage, and boasted of it, but they weren't too anxious to respond to the calls in the night.

THE MEDICAL FORUM

STATE AFFAIRS

NURSING

Wisconsin Backs Forand Bill

With a jolt that probably surprised state physicians, the Wisconsin Nurses Association, at its recent Milwaukee convention voted overwhelmingly to back the Forand Bill to provide socialized medicine for those under social security.

The resolution favoring the bill follows the line of the American Nurses Association, the only major professional organization in the health field supporting the measure.

Two striking facts were revealed by the Wisconsin Nurses Association vote:

1) only 10 of the 194 voting delegates opposed the resolution. 2) only 10, by a show of hands, out of some 350, said that they had ever read the Forand Bill.

Doctor William B. **Hildebrand**, State Medical Society president, had been asked to address the nurses convention and he warned against the "dark shades of governmental interference" in the field of free medicine.

He appealed to the nurses to join physicians in their fight against "the many attempts by government to control medicine."

But Nurse Kathleen Sward, New York City, assistant secretary of the American Nurses Association, swung the audience with arguments that health service should be available to all, regardless of ability to pay; certain groups, particularly the aging and disabled could not take advantage of voluntary health insurance.

Therefore, stated Miss Sward, compulsory health insurance for those under the federal retirement system was necessary.

It was less costly to provide health care through national income than through public welfare, she said, and it was "distasteful and degrading" to depend on relief in times of sickness.

A British nurse, Miss Catherine Jones, turned up at the convention

DR. WILLIAM B. HILDEBRAND
"Don't tell me . . .!"

to speak for her country's national health system.

"This is what socialized medicine has meant to me," she stated, "I know when I go to bed at night that every member of the community I live in and the island I come from can have, at any time of day or night, the finest medical and nursing attention available, irrespective of his income."

However, the British nurse did not mention that only one new hospital has been built in her homeland in the last ten years, despite the fact that many of the old ones were leveled in the Battle of Britain. And many responsible reports from that island kingdom deplore the deterioration of medical and nursing service available to all.

Both Mrs. Sward and Miss Jones were applauded loudly. No one, except Dr. Hildebrand, spoke against the Forand bill or socialized medicine in Great Britain.

The same arguments they use against publicly supported health care now, one delegate stated, were being used 150 years ago against publicly supported education.

Later Dr. Hildebrand laid it flat on the table before a group of physicians: "Don't tell me we don't have a job to do!"

BULLETIN

Chiro Bill Vetoed!

Governor Gaylord Nelson has vetoed a Senate bill that would have added two chiropractors to the State Board of Examiners in Chiropractic.

Said Nelson: "The board has, since its inception 34 years ago, carried out its duties in a sufficient manner prescribed by state law. There has been no valid reason offered to justify a change in its composition so far as I can see."

Nelson also stated that an increase in the board's membership would create a "definite possibility" that the board's financial reserves would be depleted.

The Governor's veto was upheld in the Senate as *Medical Forum* went to press.

AGING

AMA Regional Convention

Reports coming back from the AMA Regional Convention on the Aging, which was held in Minneapolis in mid-October, were encouraging.

On-the-spot observers noted, "tremendous" enthusiasm for the two day meeting which was cosponsored by the state medical societies of Iowa, Minnesota, North Dakota, South Dakota and Wisconsin.

In all, nearly 1,000 persons, a cross cut of midwest citizenry attended. Some 20 Wisconsin physicians were present (and at least one Wisconsin chiropractor who registered as a member of the local "health panel").

One of the key speakers was Dr. Gunnar Gundersen, immediate past-president of the AMA. He laid out the AMA six point program for the aging:

1. A realistic attitude toward aging by all people.

2. Health maintenance programs and wider use of restorative and rehabilitative services.
3. More effective methods of financing health care.
4. More skilled personnel training programs, improvement of medical and related facilities for older people.
5. Greater medical and socio-economic research in the problems of the aging.
6. Leadership and cooperation in community programs for senior citizens.

He urged all state and county medical societies to adopt this six point program.

Dr. Gundersen said compulsory retirement at 65 was "shameful waste of talent and the first step on the road to boredom." Forced retirement, he stated, is "psychological death followed by physical and mental deterioration." He continued: "Too many persons are cashiered out of the labor force."

"The best interests in older people are seldom served by pampering," he added. "When sickness strikes the most urgent need is to return that person to meaningful activity in his normal social relationships. Aging is not a huge lump of our population", stated Dr. Gundersen, "but rather 15 million individuals with 15 million human needs."

"Efforts to help the aged", he went on, "should not injure the rights of one on the pretext of helping another."

"THERE IS NOT ONE of our old people who needs medical or health care—regardless of his ability to pay—who cannot get it," said Dr. E. Vincent Askey, president-elect of the AMA, as he addressed the Milwaukee Rotary Club recently on the Forand Bill.

Jacob **Friederick**, president of the Federated Trades Council in Milwaukee, outlined labor's case: The worker fears loss of income as a result of sickness, injury, unemployment and old age. Social legislation, he believed, needs to enter these four areas. Mr. Friederick stated that labor feels this is a society problem, that social security must provide some additional protection against the fears of older people that they will lose all their worldly possessions through the costs of illness.

Elmer **White**, Wisconsin Farm Bureau, stated that the younger person needs to be educated for retirement. He pointed out that farm people have traditionally taken care of themselves in their old age, that they want no part of socialistic schemes.

"If the government and the do-gooders would leave the farmers alone," he stated, "They could save up enough money to care for themselves in their old age."

He charged that the socializer is more dangerous than the "Butcher of Budapest" (Khrushchev) could ever be.

Reverend George **Palmer**, who directs Milwaukee's Methodist Manor for the aged, outlined the role of the clerics. His theme was one which has been underplayed in all discussions of the aging: return to the old closeness of the family and church, the family responsibility for their aged, shoot for higher standards of family responsibility.

Dr. A. M. **Hutter**, Fond du Lac, chairman of the State Medical Society's Division on Aging, outlined the role of the state and local community in meeting the challange of aging.

"Senior citizens deserve all the privileges they enjoyed during their productive economic years," he said. "Among these", he went on, "are freedom of choice of their medical care and hospital facilities, the ability to purchase and retain insurance against unanticipated costs of health care, the retention of the right of privacy, and above all, a preservation of the dignity and constitutional guarantees."

He described in detail the intensive work that has been done by physicians on the problems of the aging, both in his Fond du Lac County Medical Society, and at the Wisconsin level and nationally.

The full force of the community should be given to foster more golden age clubs, said a club representative. Paul **Fleer**, State Board of Health, outlined the pilot study in Green Bay where therapy has rehabilitated many of the chronically ill and bed-ridden.

The Milwaukee *Journal's* editorial writer, John **Baker**, emphasized yet another point: preparing the spouse for retirement as well as the person who is to join the ranks of the retired.

He said education on the aged is not only the newspapers' responsibility, but one for all educational agencies which have contact with the public.

SEE PAGE 6!

On page 6 of this issue of the Journal is a good sample of the "new look" in WPS advertising. It is shaped along the institutional line that has proved so successful.

The theme, "Sign of the Good Life in Wisconsin", does not play upon the fear of illness, so prominent in many ads, instead suggests pleasantly that WPS coverage is part of the good life.

The new ad series uses carefully-chosen pictures with a seasonal approach. The copy tie-in is that Wisconsin doctors, through WPS, are offering something good in Wisconsin life.

The series will appear regularly in the Journal, is now appearing in the following publications: Wisconsin Journal of Education, Journal of Wisconsin State Dental Society, Wisconsin Druggist, Bulletin of State Bar of Wisconsin, Wisconsin Alumnus, Wisconsin State Employee, The Municipalities, Wisconsin Counties, Mid-West Banker, Wisconsin Clubwomen.

STATE AFFAIRS

APPOINTMENTS

Board of Medical Examiners

Four physicians have been named by Governor Nelson to the eight man State Board of Medical Examiners: Dr. Thomas W. Tormey, Jr., Madison was reappointed secretary of the Board. The other appointees: Drs. Gunnar A. Gundersen, La Crosse; Thomas Henney, Portage; and Irvin L. Slotnik, Milwaukee.

MEETINGS

Div. on Chest Diseases:

¶ Heard a report on State Board of Health's cardiac screening program (operated in conjunction with mobile t.b. detection units), which has so far served 16 counties. Division will send letter to county medical societies reviewing hypertension screening program, emphasizing the desirability of cooperation, the availability of speakers from Board of Health prior to start of screening program.
¶ Heard that subcommittee, acting on House of Delegates resolution for study of dual use of t.b. sanatoria, was evaluating facilities at institutions in Illinois and Wisconsin.
¶ Plans to study problems created by increased number of out-patient services reported required for t.b. patients.

Div. on Maternal and Child Welfare:

¶ Determined that Division's maternal mortality study was producing valuable data not only for teaching at medical schools, but for doctors in practice; that the study should be continued, expanded; possibly to a hospital-staff program similar to that of clinicopathologic conferences.
¶ Discussed problems of migrant workers, suggested that two-three physicians be appointed by Commission to work with special committee of Wisconsin Welfare Council.

Div. on Public Assistance:

¶ Reviewed AMA's recommendations concerning care of indigent. Division opinion: Wisconsin's standards are equal to or more thorough than AMA suggestions.
¶ Approved of letter to county medical society presidents reiterating importance of local liaison committees with county welfare officials "to advise and counsel . . . on problems relating to medical services (for the needy)."
¶ Pointed out that such local committees can negotiate fee schedules and "assure free choice of physician."

DR. THOMAS W. TORMEY, JR.
A reappointment.

Div. on Rehabilitation:

Reviewed legal and current status of OASI disability benefit program (1.5 million applications since 1955; one-half of these rejected; 20% of these requested reconsideration; 25% of reconsiderations approved.)
¶ Heard that trend in OASI reported to be more liberal interpretation of the law; trend reported to discourage persons receiving benefits from returning to work.
¶ Noted that fee schedule used by Division is "A" schedule of SMS. May be necessary to make some changes in schedule to keep pace with medical advances, particularly in psychiatry.
¶ In view of changing medical treatment of t.b. and consequent percentage of success, the Division on Chest Diseases is asked to review eligibility of t.b. cases for disability benefits.

Div. on Visual and Hearing Defects:

¶ Appointed a subcommittee to meet with State Industrial Commission to review standards for industrial safety goggles and Wisconsin code on visual loss.
¶ Discussed with Prof. John Irwin, Director of Speech and Hearing Rehabilitation Center, University of Wisconsin, the Center's relationship to the medical profession. Center wants close association and advice of SMS in working out its problems.

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STATE AFFAIRS

INSURANCE

Federal Government Plans

Recently President Eisenhower signed the bill which established a contributory plan for health benefits for government employees. The law provides that the federal government will contribute to the cost of health benefits for each federal employee, plus his family, including those who retire after July 1, 1960.

The number of employees in Wisconsin who will be affected by the plan is estimated at upwards of five thousand, not including their families.

Each employee will be given a free choice to enroll (or not enroll at all) in one of four types of plans: a government wide service benefit plan; a government wide indemnity plan; an employees organization plan (i.e., health insurance plans of federal employees unions); also a comprehensive medical plan (i.e., a closed panel such as the Kaiser health plan).

The government's contribution to the cost of whatever plan is selected by an employee will be an amount equal to 50% of the lowest rate charged, in most instances.

The National Blue Shield Association reports that congressional intentions, in passing the law, were to provide service benefits through Blue Cross–Blue Shield type of plans.

HOSPITALS

Proposal for UW Admissions

Governor Nelson endorsed a report calling for legislation to relax admission policies at the University Hospitals. About 200 of its 700 beds are empty most of the time.

The report stated a falling patient load is incompatible with plans for boosting the size of medical school classes. A higher per patient cost, it said, also results.

Eleven recommendations were made by the study to correct the current situation:

1.) Develop more communications between University Hospitals and local physicians and officials on patient status and services offered at the University.
2.) Seek legislative authority for any new programs having a significant affect on the University Hospitals' budget.
3.) Merge all hospitals as one University of Wisconsin Hospital for legal and accounting purposes.
4.) Change present all inclusive rate for hospital care costs; instead, permit charging separately for room, board and other fees, such as medicine and laboratory fees.
5.) Permit direct admission of students and dependents.
6.) Repeal quota system which now limits counties to two admissions per 1,000 population with state and county sharing the cost.
7.) Permit state and county to share equally in care costs of public patients coming to the University through county welfare departments and county courts, but with ceiling on county share.
8.) Require veterans to pay one-half of the cost of their care, but with ceiling on total cost to veteran.
9.) State share hospital costs of state-at-large patients who have no legal settlement.
10.) Develop a formal out-patient department, with housing for patients who use it.
11.) Renovate the physical plant in the old hospital over a period of four years.

To put the legislation into effect, the legislature, now meeting, will be asked for an initial $211,000, $100,000 of which would be earmarked for remodeling.

ONE OF 18,000 TEACHERS in Milwaukee for November convention of Wisconsin Education Association, Mrs. Beatrice Small, Viroqua, stops at SMS booth. Explaining AMA "7 Paths to Fitness", provided by SMS, is Dr. Fred Hein, AMA an ex-Wisconsinite.

BOARD OF HEALTH

Causes of Death

Heart diseases in 1958 again led causes of death for the 50th consecutive year.

This fact is revealed in the new Public Health Statistics report, which was released this month by the State Board of Health.

The top causes of death, which ranked approximately the same as in 1957, were: heart disease, 14,681; cancer, 6,283; cerebral vascular lesions, 4,674; accidents, 1,964; diseases of early infancy, 1,368; influenza and pneumonia, 1,026; arteriosclerosis, 938; diabetes, 778; congenital malformations, 518; suicide, 450; and other diseases of the circulatory system, 399.

Deaths maintained approximately the same rate as during the last ten years, totaling 37,457—an increase of 272 over 1957.

STATE AFFAIRS

NURSING

Registration of Anesthetists

Wisconsin State Board of Nursing, at its 1959 fall meeting, took action regarding nurse anesthetists.

"It's the belief of the Board," said a report, "that nurse anesthetists are practicing professional nursing (as defined by state statutes)."

"The nurse anesthetists", continued the report, "need current registration as Wisconsin registered nurses in order to comply with Wisconsin statutes."

Nurse anesthetists will be considered nursing personnel and their registration will be checked annually.

MEETING IN EXECUTIVE CHAMBERS, State Capitol, recently were members of planning committee for Third Wisconsin Governor's Conference on Aging (in 1960). L. to r.: Dr. A. M. Hutter, Fond du Lac, Judge Robert W. Hansen, Milwaukee, chairman; Gov. Nelson, and Dr. Patricia Lanier, Kewaunee.

CHIROPRACTIC

"Health Care"

Another state-wide chiropractic convention has been held. This time it was the Society of Wisconsin Chiropractors ("mixers" as opposed to the "straights" who form the Wisconsin Chiropractic Association).

Major point during the Green Bay meeting was a resolution asking congress and state legislators to pass laws to permit the use of the term "health care" rather than medical care in all official publications and registers.

The group solemnly stated that it felt the health term would be more descriptive and would eliminate discrimination against other "licensed healing arts" in the practice of medicine.

Their advance program also spoke about their interest in their own healing art.

It quoted a James W. Parker: "After eight years of ground-work, we're now on the march for those 10,000 chiropractors, to do at least $25,000 each, yearly, and enhance the prestige of our profession by building 5,000 new, beautiful chiropractic clinics to show the world that chiropractic is here to stay!"

The advance program promised even more and demonstrated that chiropractors meant to do big things in the Wisconsin legislature:

"Dr. Kieffer will outline for us his gigantic program, so widely successful in Minnesota, where chiropractors are recognized under the Workmen's Compensation law, which increases the income of each chiropractor from $4,000 to $8,000 annually.

"Minnesota has $50,000 in their public relations fund this year and had the same in 1959. Minnesota's two major organizations have been amalgamated into one solid block of chiropractic public relations prowess with resulting legislative progress, and unity and harmony is enjoyed in the one organization."

One interesting point; the advance program was published after October 13 and was littered with references to chiropractors known variously as "Dr." and "D. C.".

Thus this program was published at least two weeks after the authorative letter from the State Board of Medical Examiners was mailed to all Wisconsin chiropractors telling them to "cease and desis" from all usage of the word "doctor."

Elected chiropractor officials include: M. H. Leeder, Waukesha, president; William M. Nakomoto, Milwaukee, vice-president; L. A. Yeomans, Ripon, secretary; and Donald M. Hidde, Appleton, treasurer.

One of the principal speakers at the convention banquet was a Carl Kueffer of Georgia, a member of President Eisenhower's National Physical Fitness Board.

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STATE AFFAIRS

Manitowoc Herald–Times

AN SMS SILVER TRAY went recently to Dr. Erwin C. Cary (second from right), Reedsville, who has devoted 49 of his 75 years "unceasingly" to the medical profession. Among his distinctions: honorary membership in SMS. At presentation were (l. to r.): Dr. R. J. Banker, president, Manitowoc County Medical Society; Dr. P. B. Blanchard, Cedarburg, 5th district Councilor; and Dr. A. P. Zlatnik, Two Rivers, long-time associate of Dr. Cary.

MENTAL HEALTH

New Legislation

This month, Governor Nelson signed into law a bill to establish state standards of care and treatment in Wisconsin's thirty-eight county mental hospitals.

Standards are already in existance for county homes, county nursing homes and county general hospitals.

The law was designed to tie county institutions closely to the mental health efforts of the state as a whole.

The new act adds a Milwaukee county representative to the existing joint committee on standards. It makes the committee responsible for producing a plan for county mental hospitals by June 1, 1960.

OPTOMETRY

Appointment

Don Iverson, a Hudson optometrist, has been named by Gov. Gaylord Nelson to a five-year term on the Board of Examiners in Optometry.

PHYSICAL EDUCATION

Rare Teacher's Guide

Every now and then along comes a "teacher's guide" that really lives up to expectations: brief, well-written, positive, readily understood and full of guidance.

Such a booklet is *Answers to Health Questions in Physical Education* just published by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.

Destined to guide anyone who is responsible for a school's physical education and athletic program, the 22-page report covers such subjects as infection and disease, eating, smoking, and drinking, health and safety precautions.

It provides authoritative yes-and-no answers to the age-old questions of what athletes should eat at the training table; whether sugar and honey are helpful "lifts"; and should showers be taken during menstruation.

There is a thunderous "No" to boxing as a school sport.

Single copies of the guide are available for 50¢ each from the American Association of Health, Physical Education and Recreation, 1201 Sixteenth St., N. W., Washington 6, D. C. Quantity orders: 2–9 copies, 10% off; 10 or more, 20% off.

Dr. E. H. Pawsat, Fond du Lac, long active in statewide school health affairs, served on the Joint Committee which produced this excellent booklet.

INSURANCE

Regulation Law

Governor Gaylord Nelson has signed into law the bill which would bring Wisconsin Physician Service, Blue Cross and Surgical Care under regulation of the State Insurance Department.

Said the chief executive: the new law "imposes reasonable supervision of the three non-profit plans that currently furnish prepaid medical and hospital care for more than one million Wisconsin citizens."

The new law, which regulates the forty million dollar business in Wisconsin, (and covers more than one-fourth of the state's residents), includes five specific requirements:

¶ Agents of health plans must be licensed by the Insurance Department.

¶ The non-profit corporations must file with the department all contract forms, must furnish annual financial statements.

¶ The Insurance Commissioner can examine books and practices of the corporations, establish minimum standards for contracts.

¶ The Commissioner must examine affairs of each non-profit corporation at least once each three years, submit a written public report.

¶ Rates may vary, but must be disapproved by Commissioner if they are "unjust, unfair, inequitable, misleading or deceptive."

The State Medical Society, as long as twenty years ago, advocated stricter control of health insurance plans within Wisconsin, and had backed the present law in the 1959 legislature.

Actually, Wisconsin Physicians Service has been under state insurance laws in regards to nondiscriminatory rates, investments and premium reserves. It has had to

file annual financial statements, copies of contracts, seek approval of contract forms, and report on its organization and scope of operations.

FLUORIDATION

West Bend Fight

In recent weeks the small city of West Bend has seen another of the unnecessary fights on fluoridation.

The whole thing was curious. West Bend had had fluoridated water for nine years. Then the machinery introducing the fluoride powder broke down. Mayor Walter Schmidt, a sign painter by trade, for an unexplained reason, refused to permit more fluorides to be purchased. The city council apparently went along with him, but "not in a formal meeting."

Meanwhile the anti-fluoride forces moved into action. They stormed around demanding that the 1950 fluoride ordinance be rescinded, that a new ordinance be enacted making it illegal to inject fluoride into the water. Finally a referendum was ordered for November 3.

Physicians and dentists, plus plenty of responsible citizens rallied to the fight. But the city was split down the middle on the issue.

The anti-fluoride forces got considerable support from a chiropractor named, Desire Lutz. The bone manipulator advanced his scholarly argument: "When we want drugs we can get them."

"It is very unscientific," he said. "No doctor gives the same dose of medicine for every patient", uttered this product of a cult.

Dr. J. G. Koehler, a local dentist, hit the nail on the head: "One thing that gets my goat is a chiropractor describing a dental disease. We have lay people in town talking dentistry when they don't know a cuspid from a bicuspid."

Dr. James Baumgartner was credited by the Milwaukee *Journal* as being one of the articulate spokesmen from the West Bend physicians.

On November 3 matters came to a head, and by a slight vote of 101 out of almost 3,000, the pro-fluoride forces won. The vote, however, is advisory and no one can predict the final outcome.

AUXILIARY

"We Are Only Half . . ."

At annual meeting last May, the then State Medical Society Auxiliary president, Mrs. Gordon Schulz, wished out loud that Wisconsin physicians "would request more of our services."

In a recent communication, Mrs. G. A. Behnke, Kaukauna, current Auxiliary President, spelled out some of the services that auxiliary members now perform:

"Like it or not," said President Behnke to state physicians, "we are your walking and talking representatives; in the grocery store, the churches and the PTA meetings, affairs that you are too busy to attend.

"The medical Auxiliary member," she continued, "is a better informed doctor's wife."

"But", Mrs. Behnke added, "we are only half an Auxiliary . . . we have only about half as many members as there are doctors' wives in the state. Encourage your wives to join us. We need all types of women, including the shy and retiring. Every doctor's wife is wanted and needed."

Then Mrs. Behnke concluded: "Encourage your wives to help us take medicine's story to the public. Let us directly be public relation ambassadors for medicine, as well as for you, our individual physician."

In an era when everyone claims "I have no time," it is refreshing to learn that the Auxiliary of the State Medical Society offers its time, and willingly.

TALES

Exclusive Hospital

The American Hospital Association recently sent out a questionnaire to many hospitals asking what their bylaws were. The association is studying hospital administration.

Back from the hospital in Marquette, Michigan, came the following reply:

"This is a prison hospital operated by the State Department of Corrections servicing inmates only. We have no bylaws, in-laws; we deal exclusively with OUTLAWS."

Appleton Post–Crescent

OUTAGAMIE COUNTY MEDICAL SOCIETY officers for next year look over schedule of activities. Left to right are Dr. William Dafoe, Appleton, vice-president; Dr. G. A. Behnke, Kaukauna, house delegate; Dr. J. H. Russell, Appleton, alternate; Dr. George A. French, Appleton, president; and Dr. Josph N. Bonner, Appleton, secretary.

STATE AFFAIRS

Estimated Population of Wisconsin by Sex and 5-Year Age Groups—July 1, 1958

Age	*Total*	*Male*	*Female*
0–4	468,800	240,000	228,800
5–9	408,200	209,000	119,200
10–14	354,100	181,200	172,900
15–19	282,500	143,700	138,800
20–24	255,000	129,300	125,700
25–29	237,400	114,500	122,900
30–34	250,800	123,700	127,100
35–39	253,500	123,200	130,300
40–44	246,800	121,200	125,600
45–49	234,100	113,700	120,400
50–54	207,500	102,400	105,100
55–59	190,600	92,900	97,700
60–64	170,500	83,600	86,900
65–69	144,900	69,100	75,800
70–74	110,000	51,700	58,300
75–79	69,100	31,400	37,700
80–84	38,400	16,600	21,800
85+	15,800	6,400	9,400
Total	3,938,000	1,953,600	1,984,400

POPULATION

Changing Wisconsin

Profound changes are occurring in Wisconsin's population, (see box) and each will present new problems, new challenges in the fields of health, education, business and government.

State Board of Health has just released population figures for 1958. In the past eight years the number of citizens has risen from 3,446,700 in 1950 to 3,938,000 in 1958; an increase of 14.3%.

What is significant is that this gain has not been distributed evenly among the various age groups.

The birth rate has swelled population ranks a healthy 26.8% for the 0–19 age group. At the same time those aged 65 and over increased almost as much, 21.9%. Yet the active, working population aged 20–64 has barely moved up to 5%.

If, as the Board of Health suggests, the 0–19 and 65 and over groups are considered dependents, then, in 1950, 100 producing persons were supporting 77 dependents; but today the same number support 92 persons. Thus dependents have been increasing at a rate 3½ times that of the working population.

Board of Health figures also show that migration into and out of the state does not play a large role. Since 1950, Wisconsin has gained only an estimated 50,200 through migration, just 10.2% of the total gain of 491,300 since that year.

One of the most critical changes occurring within Wisconsin from 1950 on is the movement of people from county to county. There is a major shift away from the north and the west into the urban counties south and east (with Milwaukee pushing into neighboring counties).

These 19 urban area counties* showed a gain of 24% while the rest of the state lost 2.9%.

The southeastern part gained in all age groups (particularly in the 0–19 category), while the remaining counties lost persons in the vital working years of 20–64 (though they also had lesser gains among dependents).

NEWS BRIEFS

Appointments

Dr. C. G. Reznichek, Madison, has been appointed by the Executive Committee of the Council as advisor to the University of Wisconsin chapter of the Wisconsin Student Medical Association; Dr. Edgar End, Wauwatosa, has been appointed advisor to the Marquette University Medical School chapter of the student association.

Aging Insurance

University of Wisconsin Board of Regents have accepted with "appreciation" a State Medical Society Foundation grant of $5,000. The grant will support a school of commerce research project on the insurance needs of the aging.

Medical Assistants

Wisconsin State Medical Assistants Society will hold an educational seminar January 9, 1960, at the Brooks Memorial Union, Marquette University. The 1960 state convention is planned for June 3–5 in Milwaukee.

* Outagamie, Brown, Winnebago, Calumet, Manitowoc, Fond du Lac, Sheboygan, Columbia, Dodge, Washington, Ozaukee, Dane, Jefferson, Waukesha, Milwaukee, Rock, Walworth, Racine, Kenosha.

Div. on Safe Transportation

Recently the Wisconsin County Police, Deputy, Sheriff and Radio Operators Association met with the SMS Division on Safe Transportation to request help from Wisconsin physicians in cases involving drunk driving.

The Division will attempt to work out a voluntary plan that will make doctors available for drunk driving tests.

At the same time, the division's chairman, Dr. T. W. Tormey, Jr., dispatched a letter to Governor Nelson urging that all state motor vehicles be equipped with safety belts as an example to all drivers.

New Sports Shoe

Wisconsin Interscholastic Athletic Association will spend up to $10,000 trying out a new football shoe during the 1960 season. The shoe has a one piece sole, including cleats, made of Neolite or something similar; is designed to allow greater "give", thus cut down possibility of injury.

X-Ray Technicians

Wisconsin State Society of X-ray Technicians has named Richard Bauer, Milwaukee, as president-elect to succeed the current president Charles W. Ainsworth, Wauwatosa, next year.

Other elected officials include: Sister M. Ottilia, Waupan, vice-president; Mary Graunke, Neenah, secretary; Sister M. Aloysius Marie, Madison, treasurer.

POISON CONTROL

Kenosha

OLympic 4–5311, Poison Information Center, Kenosha Hospital, Kenosha.

Madison

ALpine 6–6811, University Hospitals Poison Information Center, Madison.

Milwaukee

DIvision 4–7100, Poison Control Center, Children's Hospital, Milwaukee

THE WISCONSIN MEDICAL JOURNAL

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The Colon as Replacement for the Esophagus: Its Resistance to Reflux of Gastric Juice*

By JOSEPH J. SCHECHTER, M. D., JOSE J. YAP, M. D., and RICHARD H. SEGNITZ, M. D.

Milwaukee, Wisconsin

THE PROBLEM OF esophageal reconstruction has long been the concern of the surgeon. In those cases of tracheo-esophageal fistula in which there is not enough esophagus for a primary anastomosis, the surgeon is hard pressed to restore continuity. The problem may consist of providing a simple bypass for a benign process such as lye stricture, or it may be reconstruction of almost the entire length of esophagus following adequate resection of carcinoma. Whatever the indication, the problem remains essentially the same.

Many procedures have been utilized through the years. Their variety suggests that no completely satisfactory method has been established. The use of the right colon as an interposed segment between proximal esophagus and stomach is becoming more and more popular in various centers.[1-6]

Many have ventured into this approach to the problem because of dissatisfaction with such procedures as:

(1) subcutaneous tunnel over the anterior chest wall. This produces a bulging, cumbersome mass over the chest which prevents the patient from living in comfort or dignity;

(2) transplantation of the stomach into the chest. This causes compression of the intrathoracic organs, esophagitis, and dyspeptic symptoms; and

(3) esophagojejunostomy in the Roux–Y fashion. This frequently fails because of interference with circulation in the jejunal segment.

Because of these dissatisfactions many have begun to use interposed segments of colon or jejunum in the anterior or posterior mediastinum. Many recent reports in the literature favor colon over the jejunum. According to Sherman,[1] the greater ease of mobilization of the right colon with its unique marginal artery, plus its ability to resist peptic digestion, deserve for it favorable consideration over the jejunum. Other authors in reporting use of the right colon in a similar manner also mention the resistance of the colon to acid peptic digestion. Considerable work has been done showing that there is equal resistance of various levels of the intestinal tract to acid peptic digestion.

Dragstedt and Vaughn[7] made flaps out of segments of small bowel and colon, transplanting them into windows made in the stomach and noting subsequent ulceration. They found no difference in the various levels used. In an endeavor to prevent dumping syndrome following subtotal gastric resection, Henley[8] replaced the resected portions of the stomach with segments of jejunum in 73 patients; he reported subsequent ulceration in jejunal segments in 3% of the cases. Moroney,[9] however, used the colon as a replacement in 150 cases and reported subsequent ulceration in the colon segment in 1.3% of cases.

Dillard and Merendino[10] using dogs interposed intestinal segments in the third portion of the duodenum and found no differ-

* From the Departments of Surgery, Milwaukee County Hospital and Marquette University School of Medicine.

ence in the susceptibility to gastric secretion from a Heidenhain pouch, in jejunum, ileum or colon, thus disproving the concept that resistance to gastric juice decreases as you go down the gastrointestinal tract. These studies indicate that in regard to the relative susceptibility to peptic digestion the colon stands well.

Others[11-13] have interposed segments of jejunum and colon at the cardia, demonstrating that for short periods of time it is satisfactory. Before using the colon in reconstruction of the esophagus, it seemed to us that two questions should be answered: "How will the substituted colon segment tolerate the reflux of gastric juice, and how will it function as a passageway over a long period of time?" To evaluate this, a study was set up using dogs.

Method

The basic preparation consisted of interposing a segment of colon between proximal esophagus and a new opening in the top of the stomach, bypassing the distal end of the esophagus and cardia (fig. 1).

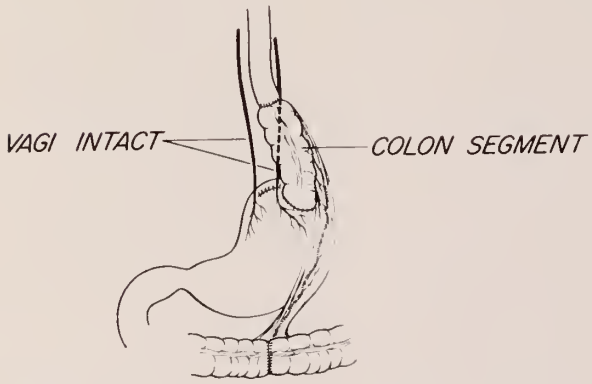

Fig. 1—The basic preparation consists of excision of the distal esophagus, closure and inversion of the cardia, interposition of an isoperistaltic segment of colon between the esophagus and stomach, preservation of the vagi, and restoration of continuity by colocolostomy.

To make the setup as simple as possible, the vagi were preserved. Mongrel dogs, weighing 10 to 15 kg., were prepared by neomycin*, castor oil, and colonic irrigations. After anesthesia with pentobarbital (Nembutal) and succinylcholine (Anectine), given intravenously, a left rectus splitting incision was made. A segment from the transverse colon was selected from 7 to 10 cm. in length. The esophagus was freed at the cardia, both vagi were identified and spared. The distal esophagus was transected and inverted into the stomach. The colon segment was brought up posterior to the stomach and the proximal end anastomosed to the esophagus with a two-layer interrupted anastomosis. The distal end of the colon was anastomosed to a new opening in the fundus of the stomach. The colon continuity was restored by colocolostomy. The abdomen was closed in layers.

Eight dogs survived this procedure. These dogs were studied up to one year in regard to weight, endoscopy, fluoroscopy, and x-ray. Following this study the colon segment was stressed, utilizing a standard ulcerogenic method (histamine in beeswax)**. A vagotomy and Finney pyloroplasty were done on part of the dogs before this stress in an endeavor to protect the colon segment.

Results

One dog was sacrificed at the end of four weeks. Postoperatively he had had an obviously stressful existence because of an evisceration which was repaired. The esophagus, colon segment, stomach, and duodenum were normal in appearance.

The seven remaining dogs were transferred to the University farm and allowed a normal canine diet. They were maintained there for a year. *They ate normally and maintained their weight* (fig. 2). One had a nice litter of puppies. The fact that all of these dogs maintained and gained weight demonstrates that the colon acts physiologically as a good passageway for food swallowed. We feel that this evidence accumulated over a year's time is most significant.

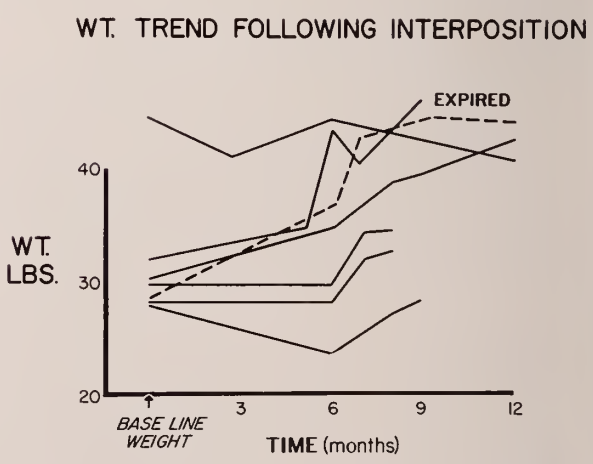

Fig. 2—Postoperative weights showing maintenance of weight even in the one dog who spontaneously developed an ulcer and died.

* Supplied by the Upjohn Company, Kalamazoo, Michigan.

** Supplied by Hoffman-LaRoche, Inc., Nutley, New Jersey.

At 10 months postoperatively one dog died suddenly. At the time he was maintaining his weight and looking fine. Examination revealed a perforated ulcer in the colon segment, which was not at the suture line, and grossly had the appearance of a peptic ulcer.

At this point the six surviving dogs were studied extensively. Endoscopy of the esophagus and the interposed colon segment was done. In addition, fluoroscopy and x-ray studies were obtained utilizing barium (fig. 3). The colon segment was noted to be very irritable and spastic. Active peristalsis was seen in all segments. No evidence of ulceration or malfunction could be detected on any of these examinations.

In order to study the dogs under stress, daily intramuscular histamine (30 mg.) in beeswax injections were begun. Prior to this the histamine preparation was standardized in Heidenhain pouch dogs. On receiving the injections all six dogs became desperately ill. Three died after only six or seven daily injections of the histamine. Post mortem examination showed perforation of ulcers in the colon segments (fig. 4), with ulcerations elsewhere—duodenum, stomach, etc. The remaining three dogs were examined with an esophagoscope with changes noted in all colon segments. The histamine injections were stopped and the three remaining dogs allowed to recover from the stimulation.

After one month, to allow for healing, a vagotomy and Finney pyloroplasty were done on the three remaining dogs in an effort to protect them from peptic ulceration. After a suitable time for recovery from this operation, these dogs were again subjected to the histamine stress. After four days one dog died. On examination there was evidence of chronic ulceration, with stenosis of the colon segment. This must have represented ulceration prior to this recent stimulation and does not represent a fair test of the vagotomy and

Fig. 3—A barium study showing the interposed segment functioning.

Fig. 4—Photograph showing perforation in colon segment produced by histamine stimulation in dog without vagotomy and pyloroplasty. Arrows point to the perforation in the colon segment and to an ulcer in proximal duodenum.

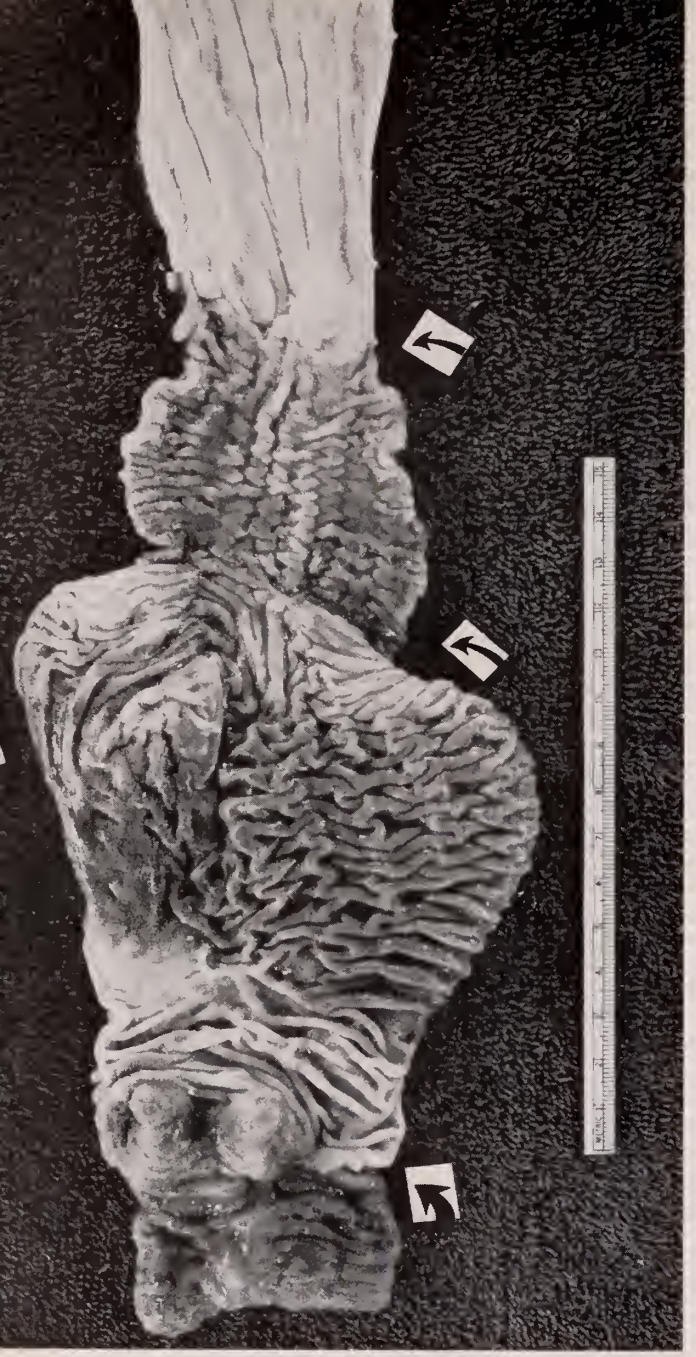

Fig. 5—Photograph showing no change in colonic segment after intense histamine stimulation in dog with vagotomy and pyloroplasty. Arrows point to the colon anastomoses, the inverted cardia, and to the Finney pyloroplasty.

pyloroplasty. The remaining two dogs were continued on daily histamine injections and were sacrificed after six weeks of stimulation. There was no ulceration found in either of the colon segments (fig. 5). An interesting observation was that the colonic mucosa had arranged itself into rugal folds, much like gastric rugae, with which they were in juxtaposition. A photomicrograph (fig. 6) shows it to be normal colon mucosa.

Fig. 6—Photomicrograph showing the mucosa of the interposed colon segment to be normal colon mucosa.

It is interesting to note that of the seven dogs eating and running on the farm, one spontaneously developed an ulcer perforation in the colon segment. As far as we can determine, the segment setup was the same as in the other dogs. Perhaps he was an ulcer-type dog. Perhaps, after a longer duration of time, more of the dogs would have developed ulcers from the reflux of gastric juice, thus pointing out the value of a longer time study. It should be pointed out that histamine stimulation is a most severe stimulation. It is well established that in normal dogs histamine injections will cause a severe ulcer diathesis in almost 100% of dogs.[14] Perhaps we are asking too much to expect the colon to stand up to this tremendous ulcer diathesis produced by histamine stimulation.

While on this severe histamine stimulation, vagotomy and pyloroplasty protected two out of three dogs (table 1).

TABLE 1—RESULTS: INTERPOSED COLON SEGMENTS

	Changes in Colon	Normal Colon
Normal canine diet (8) (up to one year)	1	7
On histamine stimulation		
No vagotomy or pyloroplasty (6)	6	0
With vagotomy and pyloroplasty (3)	1	2

Summary

1. In dogs, the colon functions well as a passageway for food since they were able to eat, gain weight, and propagate during a one-year period.
2. In hypersecretion states the colon segment is vulnerable to the reflux of gastric juice.
3. Vagotomy and pyloroplasty protect the colon segment against an experimental ulcer diathesis.

These findings suggest that interposition of a colonic segment for esophageal reconstruction in patients with gastric hypersecretion should be accompanied by vagotomy and gastric drainage, so as to avoid subsequent ulceration of the transplanted bowel.

(J.J.S.) 324 West Galena Avenue, Freeport, Illinois.

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SURGICAL CONSCIENCE. Conscience in surgery means a strong sense of right and wrong, a willingness to help others, a feeling of compassion for the unfortunate, self-discipline, and a strong faith in the sanctity of God and man. It can be conditioned by education and experience. It depends not only on the surgeon's individual moral fiber and religious concepts, but also on his heritage of philosophical doctrines, his scientific and factual knowledge, and his judgment. It determines his conduct in many situations, such as the current difficulty with hospital-acquired infections, where temporary individual gains from the misuse of antibiotics may result in protracted trouble to a community. It compels the surgeon at times to resist popular demands and to have the moral courage to protest. It requires him to rise above the selfishness of small professional groups and to devote himself to the individual patient with gentleness, compassion, firmness, and resolution. Many of the current problems concerning the care of the sick are complicated, not solved, by rigid regulations and dictatorial authority. Their solution depends, rather, on a rebirth of the surgical conscience.—W. A. ALTEMEIER, A.M.A. Arch. Surg. 79:167–175 (Aug) 1959.

CLINICAL SIGNIFICANCE OF A LUMP IN THE THROAT. The sensation of a lump in the throat is a common complaint and is generally treated lightly, but to assume that it is purely functional without due examination in a given case is dangerous. The emotional lump in the throat is probably a spasm of the cricopharyngeus muscle, which is the lowermost portion of the m. constrictor pharyngis inferior and serves normally as the sphincter of the esophagus. The lump which moves up and down commonly represents the results of inflammation of the naso-pharyngeal mucosa after influenza. The lump with aching is most often found in women and is associated with hypothyroidism. In the case presented, however, a lump that had been assumed at first to be functional in origin and later ascribed to chronic lingual tonsillitis, was ultimately found to be a squamous-cell carcinoma on the tongue at the level of the tip of the epiglottis. The discomfort connected with pharyngitis is not necessarily proportional to the extent of the pathological changes found on examination. The temptation to explain a lump in the throat as a form of neurosis should be resisted, and the physician should use all the means at his disposal to make a diagnosis and give appropriate treatment.—G. EDWARD TREMBLE, A.M.A. Arch. Otolaryng. 70:157–165 (Aug.) 1959.

PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I Know About It,
Wis. M. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

Reprints: An order slip for reprints with a table covering cost will be sent with the galley proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

Perinatal Mortality

By HEYWORTH N. SANFORD, M. D.
Chicago, Illinois

The most dangerous day in the life of an infant is the first day of life, and the first hour of life is its greatest hurdle.

PERINATAL MORTALITY is a term that is used to indicate the death of fetuses before birth and of infants in the early days of life. It includes all products of conception weighing over 400 gm. This is the average weight of the fetus at the fifth month, and the time beyond which the delivery of a dead fetus must be reported to the health department in most states, since it is considered the dividing weight between an abortion and a birth. The age limit of survival time of the infant has varied in different reports from 10 to 28 days. However, this makes very little difference inasmuch as the majority of infant deaths take place in the first week of life.

In our Chicago area, which gives us a good example of the general pattern for the United States during the 10-year period from 1948 to 1958, infant mortality has been lowered approximately 3.5%. This reduction in infant mortality has been accomplished mostly in that group representing the latter half of the first year of life. Nevertheless there has been a steady although small reduction of the deaths in the newborn period.

Obviously to further reduce neonatal mortality, it is necessary to have an understanding of its various causes. In Chicago during the past year it was found that the greatest cause of mortality in the newborn period, excluding prematurity, was the respiratory disturbances, or abnormal pulmonary ventilation. This accounted for 60.5%, or well over one half of all deaths in the perinatal period. The second greatest cause of death was congenital malformations which accounted for 12.1% and the third was birth injuries which caused 9.7%. These three conditions alone accounted for 83% of the mortality. Of the remaining conditions, infections caused 6.8%, anoxia 6%, and blood dyscrasias 4.9%.

These proportions are only for the early days of life, and as Bundesen[1] has pointed out: as the infant grows older the picture changes. By the end of the first month of life, abnormal pulmonary ventilation has fallen to less than one third of the total deaths, while infection has increased to one third and continues to increase until during the next 11 months it causes over one half of the total mortality.

We often speak of the first day of a person's life as being the most dangerous time of his existence. This is exemplified by the fact that the total mortality for the first day of life was 35.8%, while the mortality for the next 29 days was 33.7% and for the next 11 months was 30.5%.

First Problem: Abnormal Pulmonary Ventilation

Therefore, our first problem with the newborn is to obtain proper breathing. The majority of babies adjust themselves from fetal life to the neonatal period with the minimum

From the Department of Pediatrics, University of Illinois College of Medicine.

Presented at the one hundred eighteenth annual meeting of the State Medical Society, Milwaukee, May 6, 1959.

of effort, and need no special assistance. Indications of fetal distress, and the need of the baby for help may be told by cyanosis persisting more than three minutes after birth, heart rate below 100 or over 200 beats per minute, nonestablishment of respiration after one minute, or apnea as shown by respirations continuing below 30 per minute, or over 80, poor muscle tone, or absence of reflex irritability. Apgar[2] has devised a method of scoring these indications in a rating from 0 to 10 which greatly helps in evaluating the condition of the infant.

The Committee on the Fetus and Newborn[3] of the American Academy of Pediatrics has issued a pamphlet on "Resuscitation of the Newborn Infant," which can well serve as a standard for any of the procedures required. They emphasize gentle aspiration and ventilation with oxygen after the air way has been cleared. If respiration is still inadequate, the oxygen may be administered under controlled intermittent pressure of 15 to 20 cm. of water. If this is not effective direct laryngoscopy may be used, but they warn that instrumentation may cause irreversible injury. Respiratory stimulants are of no value, but antibiotics are advisable after extensive resuscitative measures.

There may exist certain pathologic factors that make these procedures insufficient. One of the most frequent is atelectasis. This may be a diffuse process or a combination of atelectasis and emphysema, since factors favorable to air trapping may lead to interstitial emphysema, pneumomediastinum, and pneumothorax. Occasionally the atelectasis may be localized to one or two lobes from the obstruction of a large bronchus. In this case, bronchoscopic aspiration will give immediate relief. This condition should always be suspected in the newborn in all instances of cyanosis occurring at birth or shortly after. Diagnosis of the lung density may be made by roentgenogram which will also rule out other causes of cyanosis, such as congenital heart disease, intracranial hemorrhage, pulmonary infection, tracheobronchial fistula, diaphragmatic hernia, and adrenal hemorrhage. It is useless to consider this method if the atelectasis is scattered over the lung area, or if more than a single lobe is involved. In these instances we must resort to 40% oxygen, with or without humidity.

The second condition is pulmonary hyaline membrane. The chief damage here appears to be from plugging the alveolar ducts and producing secondary or resorption atelectasis. Analysis shows it to be a protein material probably fibrin, while vernix is not a constant component. Air breathing seems to be essential. It is found most often in premature infants, and those full-term infants who are born by Caesarian section, or those infants born of diabetic mothers, and those associated with prenatal toxemia in the mother. In the baby natal anoxia may be a factor.

The symptoms begin two or three hours after birth, following a period of normal breathing, with dyspnea, retractions of the costal margins and lower sternum, and grunting followed by cyanosis. Death occurs in many instances within a few hours after onset, while in others the condition persists for three or four days with recovery.

These infants, because of the membrane, must work very hard to breath, and as a result have inadequate gas exchange. They die, according to Cook,[4] from exhaustion of the respiratory muscles, sometimes combined with left-sided heart failure. The treatment should be aimed first at prophylaxis, since there must be some initial place where this chain of events could be interrupted. Therefore all babies who have been anoxic, are born of diabetic mothers, or by Caesarian section, should be lavaged with 30 ml. of normal saline, and placed in 40% oxygen for 24 hours. Opinion varies as to whether detergents are of any value. I think they should be tried, but discontinued at once if the baby becomes more distressed. Silverman[5] has evidence that an 80 to 90% humidity gives a significantly lower mortality, and that this will also tend towards a higher body temperature.

Second Problem: Congenital Malformations

The second largest cause of newborn mortality is congenital defects. These may be approached from the prophylactic standpoint by a study of prenatal environment, and from a postnatal standpoint by possible correction. In the prenatal period the health of the mother is of prime importance. She should be kept as free from disease as possible especially in the earlier periods of pregnancy, as has been shown by the contraction of rubella and the development of the rubella syndrome in the offspring, of cataracts, heart disease, and mental deficiency. The maternal diet should be kept at an optimum, since it has been demonstrated at least in animals that

deficiencies of diet may often cause the development of malformations. As an example, deficiency of riboflavin in rats results in skeletal deformities and cleft palate, while deficiencies of vitamin A cause malformations of the eyes, heart, and kidneys. This would imply that some congenital anomalies are not beyond the possibility of control.

It has long been known that fetal health was disturbed by maternal disease. We have diabetes in the mother as an example. This has become a problem because the modern control of diabetes makes childbearing quite possible. Unless recognized and treated there is a high degree of mortality in these infants. They show macrosomia, cardiomegaly, edema, and erythroblastemia, and are subject to hyaline membrane.

Miller[6] has shown that the mother may not be diabetic at the time of delivery but was pre-diabetic and developed diabetes later. These babies may be helped prenatally by adequate control of the diabetes, and present an immediate problem at birth. They should be lavaged with normal saline, and they should be placed in an incubator with 40% oxygen, and treated as if they were premature. Feeding and fluids should be somewhat restricted for the first two days, and the hypoglycemia, and hypocalcemia treated as necessary in individual instances. Adrenal insufficiency associated with hyperplasia and the adrenogenital syndrome needs very close observation, since these babies may be salt depleters and therefore present a grave emergency. In the female infant the genitalia should give a clue to the condition, but the male infant will show normal genitalia. At the end of the newborn period it is well to bear in mind that babies particularly in the second or third week of life, who suddenly have vomiting, lassitude, and weight loss, may well be suffering from this condition. It is accompanied by decreased blood sodium and chloride values, and an elevated potassium. Death can take place very rapidly because the condition is frequently mistaken for pyloric stenosis, or infection. It constitutes a pediatric emergency which can be corrected at once by the administration of cortisone and desoxycorticosterone and increasing the intake of sodium, by intravenous and oral normal saline.

Congenital anomalies are found most frequently in the central nervous system, heart, and gastrointestinal tract. Those found in the central nervous system are most frequently spina-bifida, which is quite apparent, and should have neurologic consultation at once, and developing hydrocephalus which can be diagnosed by the increasing circumference of the head. This should not be more than 2 cm. in excess of the circumference of the chest except in the premature infant. This again is a problem for the neurologic surgeon.

One-fourth of all the infants who die in the first eight hours of life die in that first hour, and two-thirds of all the infants who die during the first day of life die in those first eight hours. Two-thirds of the infants who die during the first three days of life die on the first day of life, and those infant deaths occurring during the first three days of life represent almost three-fourths of all the deaths during the first month of life, and over one-half of all the deaths occurring in the first year of life.

Many defects of the heart are not apparent in the newborn period and do not lend themselves to ready diagnosis. There are, however, three conditions that should be considered, since the earlier attempts are made for their correction the better. The first is double aortic arch. Here the trachea and esophagus are encircled by a vascular ring. The symptoms are stridor, which appears during the first days of life, a barking metallic cough, and difficulty in swallowing. A barium swallow reveals a narrowing of the esophagus at the level of the aortic arch and indentation of the posterior surface in a lateral view. These symptoms are quite characteristic and the outcome may be fatal. Treatment consists in severing the smaller portion of the arch.

The second cardiac defect is the infantile type of coarctation of the aorta. Here the aorta is narrowed from the origin of the left subclavian to the insertion of the ductus arteriosus. The femoral pulse will be absent, and this should always arouse enough suspicion to estimate the blood pressure in both extremities, and that of the upper extremity will be found to be considerably higher than the lower. Immediate operation should be considered since this is not compatable with life after the closure of the ductus. Recently we followed such a child until three weeks of age when signs of failure developed. An operation was then performed, and the condition was successfully corrected.

The third malformation is tricuspid atresia, or stenosis. The type amenable to surgery consists of atresia plus interauricular communication, hypoplasia of the right ventricle, atresia of the pulmonary artery and a patent ductus, or intraventricular septal defect. These children have cyanosis, systolic murmur, a large left ventricle as shown by roentgenogram, and a left axis deviation by the electrocardiogram. We have had several such infants survive operation at the end of the newborn period. This should be attempted since the condition is not compatable with a long life span.

Anomalies of the gastrointestinal tract have the three cardinal symptoms of vomiting, distention, and absence of stool. These are always danger signals of the utmost importance. Vomiting of the first food or water, with drooling, choking and respiratory difficulty should always make one think of esophageal atresia with tracheobronchial fistula. This would indicate immediate attempts to pass a catheter into the stomach and esophageal examination with an opaque media. Immediate surgical repair should be initiated.

Pyloric or duodenal vomiting due to an obstruction at either of these levels of the small intestine is explosive, and contains stomach contents. Obstruction at a still lower level, either of the small or large intestine, may be delayed in its onset, but is usually preceded by distention at the point of atresia. Here the vomiting is fecal.

If the obstruction is above the ampulla, the stools will be normal meconium. If it is below the ampulla, the stools will be grey, white, and mucoid. The greatest help in these conditions has been through the studies of Wasch and Marck.[7] They found that in the normal newborn, air could be found by roentgenogram in the stomach at birth. Between the first and the third hour of life the small bowel is filled; by the eighth hour closely packed segments of the small intestine fill the abdominal cavity; and at the end of twelfth hour the normal pattern is established. This makes a contrast medium unnecessary, is much safer for the infant, and only requires a flat plate of the abdomen. Therefore, early diagnosis can be made with corresponding earlier surgical intervention. Needless to say, these newborn should be in good physical condition for the surgical procedures, giving by transfusions, adequate fluids and electrolytes.

Third Problem: Injuries

While injuries at birth were found to be the third greatest cause of newborn mortality, it is doubtful if they are all properly classified. A great number of these have other conditions or anomalies of the fetus as the actual background. Also the vast majority occur in the premature infant, where its fragile blood vessels are a frequent cause. Fortunately, we have about abandoned the old idea that it is always caused by indifferent obstetrics. The diagnosis of cerebral hemorrhage is not easy, and with frequent autopsies it has been found that many which are given this clinical diagnosis are in fact due to some other etiologic factor. I believe that to make a clinical diagnosis it is necessary for the baby to show: (1) cyanosis, (2) convulsions, and (3) spasticity or flaccidity. Spinal punctures are of doubtful value even in making the diagnosis since the finding of red blood cells in the fluid is not uncommon in the normal newborn. The treatment consists of absolute rest, a minimum of handling, elevation of the head, and delayed feeding. Vitamin K is of doubtful value, and if given should not exceed 5 mg. and not repeated. The importance of subdural hemorrhages in the development of hematomas is being more widely recognized. These usually do not develop for at least a week after birth. Any child who takes food poorly, does not gain satisfactorily; and who has the slightest evidence of increased intracranial pressure, such as fullness or tightness of the fontanel, should have an exploratory needle tap of both subdural spaces through the fontanel. This is very safely done, and the withdrawal of residual blood may be life-saving. If the fluid returns, through osmosis, surgical removal of the sac may be indicated.

These three conditions, respiratory disturbances, congenital malformations, and injuries at birth, account for four fifths of the total mortality of the newborn period. The remaining conditions, however, are of considerable importance because it is among them that further reductions in newborn mortality may be made. The first of these is infections which cause 6.8% of the newborn deaths. It is interesting to note that this compares very well with the last five years, being 6.2% in 1953. There has been so much recent discussion about the increase in infections in newborn nurseries, particularly from the staphylococcus, that it is interesting to see

that this has had no apparent change in newborn mortality in our area.

Infections may be suspected in any condition in which there has been any diabetes or other illness in the mother, a difficult delivery, or premature rupture of the membranes. Therefore, prophylactic antibiotics should always be administered to the baby. The clinical symptoms are enumerated in table 1. It might be emphasized that meningitis

TABLE 1—DIAGNOSIS OF INFECTION IN THE NEWBORN

Prenatal History	Illness of mother Difficult Delivery Rupture of membranes 24 hours prior to delivery Diabetic mother
Clinical	Fever over 37.8 C. Sudden, often transient Hepatomegaly Abdominal Distention Icterus Classical signs of sepsis, but seldom present (sclerema, omphalitis, splenomegaly, and bleeding)
Laboratory	Positive blood culture Occasionally pyuria, and leukocytosis (over 24,000)

differs somewhat, and it is most necessary that diagnosis be made at once and immediate treatment begun. Irritability and anorexia occurring without explanation in the newborn period should always suggest the possibility of meningitis. Meningeal irritation as shown by stiffness of the neck, positive Kernig, and Brudzinski's sign are seldom observed. Usually a slight bulging or boggyness of the fontanel is the only sign of increased intracranial pressure.

If infection is suspected antibiotics should be administered immediately following blood culture, umbilical stump and urine culture, and spinal fluid examination. Appropriate changes may be made in therapy when the individual organism has been cultured. Newborns tolerate antibiotics very well, if they are prescribed in minimal quantities. Smith *et al.*,[8] in reporting a series of septicemias quite successfully treated, suggest initially chlortetracycline intravenously 20 mg. every 12 hours, or 50 mg. orally every 8 hours, penicillin intramuscularly 100,000 units every 6 hours, and sulfadiazine 15 mg. subcutaneously every 8 hours. Later changes may be made to correspond to the sensitivity of the cultured organism.

The peculiar type of reaction to infection in the newborn as shown by the staphylococcus depends on several factors. One is the presence of coagulase positive organisms such as strain 80/81 which have the ability of precipitating fibrin, thus blocking the blood barriers to protective factors. It is quite impossible to eliminate these organisms since Fairchild[9] found that 44% of newborn had them on the umbilical stump within the first 24 hours of life, and 91% by the fifth day of life. They persisted in 28% until 30 days of life. However, their nursery was under sterile control and no infections developed. This shows that if good techniques of care are used there will ordinarily be no difficulty.

Titres of antistapholysin in fetal serum are equal to or greater than those of maternal serum. However they are reduced in the premature infant. In general, the newborn infant resists invasion by the staphylococci surprisingly successfully. To some extent this may depend upon the presence of maternally transmitted antibodies, but it must also depend to a greater extent on the so-called first line of defense, the skin and mucous membranes. These organisms readily colonize mucous membranes in infants. Under the usual conditions prevailing in most hospitals, staphylococci that colonize the nose of the newborn infant come from the personnel of the hospital nursery rather than from the mother. The nasal carrier state may involve from 20 to 100% of the newborn infants in a nursery. At the same time, lesions caused by the staplylococci usually affect less than 1% of the babies.[10]

Conditions favoring an epidemic are the presence of an unusually virulent strain of organisms in large numbers, inexperienced personnel, and relaxed aseptic technique. The presence of culturable staphylococci in water, blankets, dust, equipment, and even air of the newborn nursery is an end result and not the cause of the epidemic. When the recommendations of the American Academy of Pediatrics on Techniques of Care of the Newborn were carried out, infections were almost eliminated from newborn nurseries. It was only with the advent of antibiotics, when it was believed that they could be a substitute for good nursery techniques, that difficulties have been encountered. It has been only since the relaxations of these rules that we have had these epidemics. If hospitals will completely return to these regulations as recommended by the Academy 20 years ago, very little trouble will be encountered. In Chicago where the Health Department insists that

these nursery regulations be enforced, we have had no more trouble in recent years than before.

Lastly, blood dyscrasias caused 4.9% of the total mortality. These actually fall into two groups, those that cause anemia by loss of blood, and those that cause anemia by the hemolysis of blood. One should remember that hemorrhage is a syndrome and not a disease, and requires a diagnosis of the cause. These are usually infections or some malformation which will respond to antibiotics or surgical exploration. Coagulation defects are uncommon and will all respond to a transfusion of 10 ml./lb. of fresh blood. I would like to call attention to a condition that was first emphasized by Chown.[11] This is fetal blood loss during the birth process, from cord hemorrhage, rupture of vasa praevia, placenta praevia cesaria, or bleeding into the maternal or twin circulation. This may be observed at birth by shock, pallor, or cyanosis and lack of response to stimulation. These conditions require immediate transfusion. Later in the newborn period less severe hemorrhages may be indicated by a nonhemolytic anemia during the first week of life.

Most infant deaths occur during the first three days of life, and most of these deaths occur in infants who weigh under 1,500 gm. at birth (2.5 lbs.). Most of these deaths are due to just three things: abnormal pulmonary ventilation, congenital malformations, and injuries occurring at birth.

Hemolytic disease of the newborn has been discussed so much recently that very little need be said about it. I think we all agree that the most important thing of all is its early diagnosis and treatment. Inasmuch as an ABO incompatability can cause this condition almost as frequently as an Rh incompatability, it is best to rely principally on the presence of jaundice in the baby during the first 72 hours of life. If the cord blood total bilirubin is over 4 mg., or if it is present in the baby's plasma over 10 mg. in the first 48 hours of life, a replacement transfusion of 500 ml. of blood of appropriate type is given. It the total bilirubin again rises over 10 mg. before the third day of life in full term infants, or the seventh day of life in premature infants, replacement transfusions are repeated as necessary. Obviously if the baby is born edematous, or develops jaundice within the first few hours after birth, replacement transfusions are given immediately, and we do not wait for the bilirubin estimation. Therefore there is no delay in an obvious emergency. Oxygen and antibiotics are also a necessary part of the treatment.

Table 2

Notify Doctor Immediately if:	
Jaundice in first 24 hours	Poor sucking
Pallor	Vomiting
Cyanosis	Loose stools
Breathing poorly	Excessive drooling
Twitching	Abdominal distention
Sluggishness	Elevated temperature

"Baby Does not Look Right"

In studying newborn mortality in Chicago we have found by analysis of the histories of those babies who have died, that one possibility of improvement lies in the rapidity of diagnosis. It seems hard to realize that there is only one chance of treatment in many newborn, and that is immediate. The diagnoses of fatal conditions were frequently suspected, but not acted upon. It is felt that there are a few very important signs and symptoms that must be considered as an immediate warning and danger signal in the care of the newborn. Nursery nurses should be taught to observe these and notify the attending pediatricians at once when they occur. We should try to emphasize the importance of these signs to our students and interns. These signs are shown in table 2. It is by immediate action when these danger signals appear that we can hope to save more lives in these little people.

Summary

In summary, therefore, the principal conditions that endanger the life of the newborn and affect perinatal mortality have been shown.[12] An attempt has been made to indicate what conditions seriously affect the newborn in the early days of life. It is felt that while the perinatal mortality has not greatly decreased in the last few years,[13] nevertheless it has decreased although slowly, and may be reaching an irreducible minimum. Any improvement that may be made is related to a return to a complete sterile technique in the newborn nursery rather than relying on antibiotics for prophylaxis, and the recognition and more rapid treatment of certain emergency newborn conditions. It is in this

early period of life that an individual is in the greatest danger, and where a more hopeful outlook for that period which has been identified by C. A. Smith as "The Valley of the Shadow of Birth" should be gained.

840 S. Wood Street (12).

If all of the deaths occurring in the early days of life were carefully investigated to determine whether any neglect in the care of the mother or infant occurred; and if everyone connected with the prevention of such deaths, including the obstetrician, pediatrician, hospital administrator, nurses, and the health officer, were to learn from these cases what to do to prevent such deaths in the future; and if they were then to establish and carry out the measures necessary for correction on the basis of such knowledge gained, we could say that these infant deaths had not been in vain, and we could approach more closely the irreducible minimum of infant mortality.

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OCULAR MANIFESTATIONS OF THE CHRONIC RENAL TUBULAR INSUFFICIENCY SYNDROMES. It is now possible to explain the association of certain conspicuous types of ocular disorder with insufficient renal tubular reabsorption. Three such disorders are Lowe's cerebro-ocular syndrome (congenital or early infantile cataract with hydrophthalmos), pseudohypoparathyroidism, and Fanconi's syndrome (vitamin D-refractory rickets with other extensive metabolic disturbances). A case of Lowe's syndrome in a boy-baby 3 months old is described with emphasis on the ocular and urinary findings. Pseudohypoparathyroidism was observed in a man aged 39 who had always been confined either to his home or to an institution because of profound mental and physical deficiencies including progressive impairment of vision. In Fanconi's syndrome (not illustrated) cysteine crystals appear in the conjunctiva and cornea. These disorders are readily understood when it is considered that renal tubular reabsorption concerns the phosphates, amino acids, and basic elements. They are important to the ophthalmologist because the characteristic findings enable him to contribute valuable diagnostic information to the internist and others concerned in the treatment of these severe derangements of metabolism. Exact diagnosis is essential not only for effective treatment but also for counselling families in which these derangements occur.—HAROLD F. FALLS, A.M.A. Arch. Ophth. 62:188–195 (Aug.) 1959.

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Some Newer Aspects of Peripheral Vascular Surgery*

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RECENT DEVELOPMENTS in peripheral vascular surgery have been concerned mainly with new materials for use as artery substitutes and their methods of employment. Less attention has been paid to the natural history of disease conditions that require their use. There should be a better balance in emphasis, I believe, and for this reason will present some of the newer concepts about atherosclerosis obliterans, especially the patho-anatomic features and their relation to clinical manifestations and treatment.

Atherosclerosis Obliterans

Atherosclerosis obliterans, the most common cause of occlusive vascular symptoms, is a systemic disease and in its early stages frequently is found only in isolated segments of the arterial tree. The earliest obliterative changes occur in the aorta distal to the renal arteries, in the superficial femoral artery in the region of the adductor canal, and in the smaller arteries below the knee.

Atherosclerosis obliterans as a cause of obstruction of the arterial tree above the inguinal ligament is infrequent;[1,2,3] however, when it does occur, pain in the hip or back or reduced exercise tolerance may be the only symptom. The femoral pulses are usually absent or diminished.

The obliterative process begins in the distal abdominal aorta or common iliac arteries and when complete, secondary thrombosis takes place. Initially, the thrombus appears to advance proximally to occlude the abdominal aorta below the renal arteries, and later extends distally to involve the common iliac artery, and in a few instances, the entire ileo-femoralpopliteal artery. According to De Bakey,[4] this latter event is the exception rather than the rule, and in his experience the arteries in the lower limb are seldom involved in those cases where aorta-iliac occlusion is the principle problem.

It is apparent that extension of the thrombus, either proximally or distally from the aortic bifurcation, will result in progressive obliteration of the collateral circulation. When it occurs, intermittent claudication is exaggerated and rest pain is often seen. Gangrene of the foot or toes is a late manifestation of this condition.

Due to the regional localization of this type of vascular lesion, and the fact that a suitable "runoff" is available to receive the flow of blood beyond the site of obstruction, surgical procedures are now being employed to treat this entity. They are as follows: (a) thromboendarterectomy, with removal of the thrombus by direct arterectomy, or (b) excision of the obstructed aorta-iliac segment and replacement or bypassing by a suitable artery substitute. In each instance, peripheral blood flow is re-established.

The most common sites of obliterative disease are seen in the larger arteries of the lower limb. The earliest obliterative changes are usually seen in the superficial femoral artery as it passes via the adductor canal to form the popliteal artery. It is believed that once this artery becomes obliterated in this area, secondary thrombosis follows (fig. 1). Early in the course of these events, collateral circulation is usually sufficient to supply the resting needs of the extremity; however, with exercise, intermittent claudication of the calf muscles are noted, and absent pulses below the femoral artery are the dominant

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Fig. 1—Arteriogram showing segmental occlusion of the superficial femoral artery. The occlusive area is short and localized to the superficial femoral artery in the region of the adductor canal. The patient's principal complaint was gangrene of the big toe. A thromboendarterectomy was performed, the toe amputated and a useful foot obtained.

Fig. 2—Arteriogram showing a later stage of this disease with complete femoral-popliteal artery thrombosis. The popliteal artery and the small arteries below the knee are patent and fulfill a prime prerequisite for direct arterial reconstruction. This patient had intermittent claudication for three years which was relieved by the insertion of a bypass extending from the femoral artery to the popliteal artery.

Fig. 3—Arteriography demonstrating femoral-popliteal artery thrombosis associated with severe atherosclerosis obliterans of the leg arteries. Note the irregular contour of the popliteal artery, suggesting intimal thickening. In addition, the anterior and posterior tibial arteries are not visualized. The only artery supplying the leg is the peroneal artery, and it shows multiple areas of intimal thickening and stenosis. The patient had intermittent claudication for three years and entered the hospital because of impending gangrene of the foot. A bypass graft was inserted from the femoral to the popliteal artery, and although it remained patent, a below-knee amputation was required. It is questionable whether direct arterial surgery should be performed under such conditions, unless amputation is to be avoided.

Fig. 4—Arteriogram showing the final stages of atherosclerosis obliterans with failure of the popliteal artery to be visualized by arteriography. Collateral circulation is extensive. Patient had progressive intermittent claudication for eight years, and when first seen, gangrene of the toes and rest pain were present. A below-knee amputation was required.

clinical signs. In time, the thrombus grows in a proximal direction so as to completely occlude the superficial femoral artery to the origin of the deep femoral artery (fig. 2). As a result, collateral circulation fails, exercise tolerance is reduced, intermittent claudication increased, and rest pain and gangrene of the toes are often evident. For some unknown reason, the thrombus seldom extends distally to involve the popliteal artery, and if it does, it limits itself to that portion of the popliteal artery above the knee joint. Thromboendarterectomy or the use of a bypass graft will restore peripheral circulation.

When the obstructed segment is short and discrete,[1,4] a thromboendarterectomy is the procedure of choice; in those cases where the femoral-popliteal thrombosis is complete,

a suitable artery substitute, either dacron or teflon, or an autogenous vein graft is employed to bypass the area of obstruction.[4] The arterial tree distal to the point of obstruction must be patent if these procedures are to be successful.

Once femoral-popliteal artery thrombosis has taken place, the smaller arteries below the knee, namely, the posterior tibial, the anterior tibial, and the peroneal arteries, become involved; however, the obliterative process is more diffuse and multifocal in distribution, and the secondary thrombosis that follows is extensive (fig. 3 and 4). If collateral circulation is inadequate, rest pain, ischemic neuritis, gangrene of the toes and feet frequently follow. When atherosclerosis obliterans has advanced to this degree, the capacity of the distal arterial bed is generally inadequate to receive the "runoff" even though the occlusive segment is bypassed by a grafting procedure. In addition, in many of these patients, the popliteal artery, although patent, is frequently involved by atherosclerosis to the extent that anastomosis is technically impossible to perform.

What governs the speed and development of atherosclerosis obliterans and the thrombus formation that follows is highly conjectural. It is recognized that patients tolerate femoral-popliteal thrombosis as well as aortic-iliac occlusion for a number of years before collateral circulation fails and the small arteries below the knee become implicated. On the other hand, the obliterative changes may take place quite rapidly with femoral-popliteal thrombosis and the arteries below the knee becoming involved almost simultaneously. However, in many patients with peripheral ischemia, irrespective of their clinical manifestations, the atherosclerotic lesions may remain localized and thus permit some type of reconstructive arterial surgery to be performed. The success of these procedures depends on the degree of arterial involvement. Translumbar-aortography or femoral arteriography are the only means of determining the type and extent of the occlusion, and the patency of the distal arterial tree.

Frequently the physician does not see the patient until irreversible changes have taken place and the fate of the limb determined. In addition, renal, cardiac and cerebral manifestations of arterial insufficiency may also be present. However, all patients with clinical manifestations of peripheral ischemia, and especially those who may need an amputation, deserve a thorough evaluation of the arterial tree including arteriographic visualization of the artery thought to be involved from the clinical examination. Those patients who are relatively free of systemic vascular disease have an excellent chance of benefiting from thromboendarterectomy or a grafting procedure to bypass the obstruction.

Summary

A resumé of the patho-anatomical features of atherosclerosis obliterans has been presented. In many instances, the arteriosclerotic lesions are localized to certain segments of the arterial tree, a feature which permits the newer types of arterial reconstructive procedures to be employed in certain selected cases.

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EDITOR'S NOTE:

In the November issue of the *Wisconsin Medical Journal*, page 639, the author has called attention to an omission in the article, "A Critical Review of 515 Consecutive Surgical Cases from a Small Community-type Hospital." In the fourth line of the article and between the words "series" and "covering" the following phrase should have been included: "from the files of the Plymouth Clinic."

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

"March of Medicine" is in its fourteenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 47 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	4:45 p.m.
*WLBL	Auburndale	Friday	10:30 a.m.
WGEZ	Beloit	Saturday	10:45 a.m.
WWIS	Black River Falls	Saturday	9:10 a.m
*WHSA	Brule	Friday	10:30 a.m.
*WHKW	Chilton	Friday	10:30 a.m.
*WHWC	Colfax	Friday	10:30 a.m.
*WHAD	Delafield	Friday	10:30 a.m.
WBIZ	Eau Claire	Sunday	7:00 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
WFAW	Fort Atkinson	Saturday	10:30 a.m.
KFIZ	Fond du Lac	Thursday	7:15 p.m.
WTKM	Hartford	Tuesday	11:00 a.m.
WHSM	Hayward	Saturday	8:05 a.m.
*WHHI	Highland	Friday	10:30 a.m.
*WHLA	Holmen	Friday	10:30 a.m.
WCLO	Janesville	Tuesday	8:15 p.m.
WLIP	Kenosha	Saturday	9:05 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
*WHA-AM	Madison	Friday	10:30 a.m.
*WHA-FM	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:15 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Sunday	10:30 p.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Saturday	1:45 p.m.
WCCN	Neillsville	Saturday	9:00 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	9:05 a.m.
WPDR	Portage	Thursday	10:15 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WWCF-FM	Poynette	Sunday	3:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:30 p.m.
WRDB	Reedsburg	Saturday	12:45 p.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Saturday	5:15 p.m.
WCWC	Ripon	Saturday	9:15 a.m.
WTCH	Shawano	Sunday	6:45 p.m.
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTRW	Two Rivers	Saturday	11:15 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
*WHRM	Wausau	Friday	10:30 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	11:15 a.m.

* Radio stations in the state network.

Newer Concepts in the Medical Treatment of Duodenal Ulcer

By C. JOSEPH DeLOR, M. D.

Columbus, Ohio

THE TREATMENT of duodenal ulcer is the control of the increased acid gastric juice found in this disease. This is accomplished by the inhibition and neutralization of the acid peptic factor. In addition to this, the role of heredity,[1-5] stress,[6, 7] habits, drugs,[8-13] endocrinopathies,[14-16] burns,[17,18] and intracranial lesions,[19] must be taken into consideration and when possible these factors are corrected.

Gastric Secretion

Hypersecretion, hyperchlorhydria, and elevated pepsinogen levels,[5,8,20-26] are the most consistent findings in duodenal ulcer. This is in contrast to that found in gastric ulcer in which the volume and concentration of acid gastric secretion may be normal or less.[20] The secretion of gastric juice is divided into the cephalic, gastric, and intestinal phases under control of neurogenic and hormonal mechanisms.[27] Cerebral stimuli transmitted through the vagus nerve to the parietal cells of the stomach constitute the cephalic phase. These stimuli may be the result of a conditioned reflex such as a thought, sight, odor, or smell of food. Another form of neurogenic stimulation is that seen in insulin-induced hypoglycemia. Anger, hostility, anxiety, and other emotional states,[28,29] likewise produce hyperemia of the gastric mucosa, hypersecretion, and hypermotility. In the human approximately 80% of the gastric secretion occurs as the result of neurogenic stimulation. The gastric phase of secretion constitutes another 15% of the total. This is brought about by the hormone gastrin, produced by the gastric antrum. Mechanical distention of the stomach and chemical stimuli are capable of producing responses through this route. The remaining 5% of gastric secretion is the result of intestinal hormone stimulation. As already stated, in duodenal ulcer there is a marked increase of hydrochloric acid over that seen in the normal individual. A 12-hour nocturnal specimen of 560 cc. or less volume is considered normal with no more than a total of 20 mEq. per liter of hydrochloric acid.[20, 30] Patients with duodenal ulcer frequently treble these figures. Random and fractional gastric aspirates,[31-34] of 50 mEq. per liter or more are significant and particularly so if a sustained elevation is obtained at the end of 2 hours following the use of such stimulants as caffeine.

Food as a Secretory Stimulant

All food will stimulate the stomach to secrete, but some things such as coffee,[32,33] tea,[35,36] alcohol, seasonings,[37] drugs,[10-12] and chemicals[31] are more potent than others. The main xanthine in coffee and tea is caffeine which is one of the most potent gastric secretory stimulants known. Orange juice,[38] both fresh and frozen, has been demonstrated to produce marked elevations in acid gastric juice and it is well recognized by many that some individuals with peptic ulcer do not tolerate this food in their diet. The same can be said of such seasonings[37] as black pepper, chili pepper, cloves, mustard seed, and nutmeg. These latter substances are also capable of producing heartburn, belching, and nausea in active ulcer patients.

Drugs and Hypersecretion

Caffeine, already mentioned as a potent secretory stimulus, is found in such drug preparations as the common phenacetin, aspirin and caffeine tablet, ergotamine with caffeine (Cafergot) and caffeine sodium benzoate. Salicylates too have been accused of an irritating effect on the gastric mucosa, and this is particularly significant in peptic ulcer in older patients who consume salicylate preparations regularly for the analgesia

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From the Division of Gastroenterology, Department of Medicine, Ohio State University.

Presented at the one hundred eighteenth annual meeting of the State Medical Society, Milwaukee, May 5, 1959.

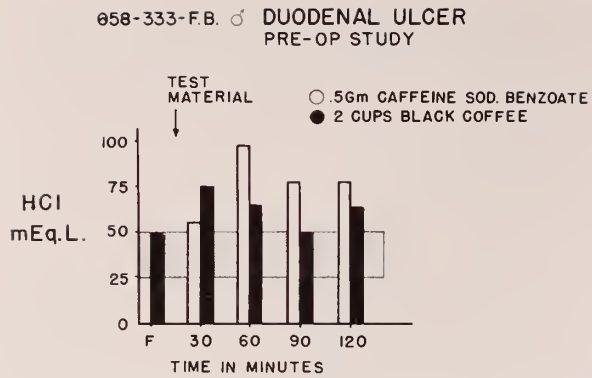

Fig. 1—The relative potency of caffeine and black coffee in stimulating the secretion of hydrochloric acid shows a close correlation between these two substances.

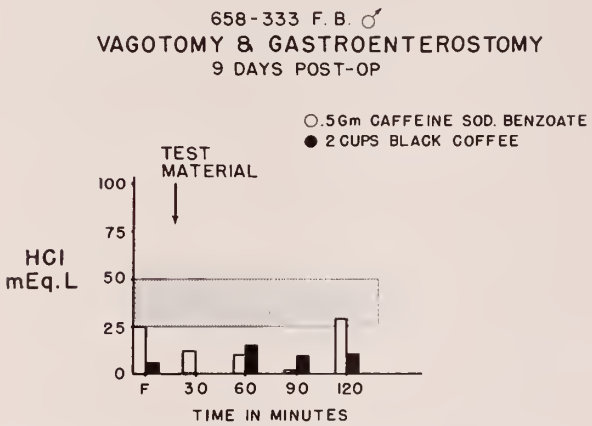

Fig. 2—Same patient as in figure 1 after vagotomy and gastroenterostomy. Caffeine appears to be effective through the cephalic pathway (neurogenic).

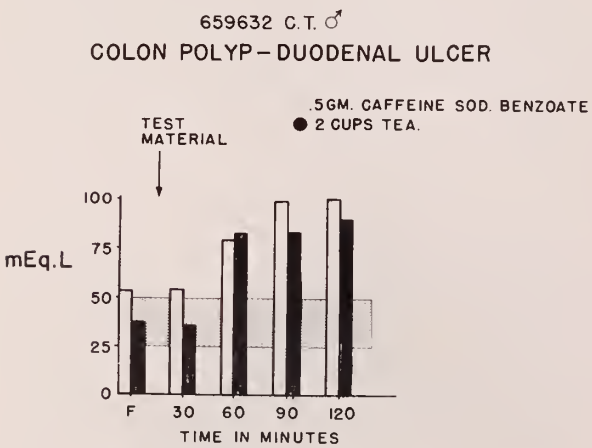

Fig. 3—A comparative study of the effect of caffeine and tea as secretory stimulants in a patient with duodenal ulcer.

of infirmity. The effect is presumably due to local irritation rather than hypersecretion(?). Histamine has been used for many years as a secretory stimulant; it has also been used for therapeutic purposes in cephalgia. Phenylbutazone (Butazolidin)[39] and Rauwolfia[9,13,40] have also been accused of ulcerogenic properties. One curious fallacy is the peppermint flavoring in antacid preparations. As little as 2 drops of oil of peppermint diluted with water will effect an abnormal rise in hydrochloric acid.

Inhibition of gastric secretion is brought about by several substances. Anticholinergic drugs are vagal suppressants and therefore inhibit the cephalic phase of secretion, but not the antral or intestinal phases. The precursor of serotonin, 5 hydroxytryptophan,[41] has been demonstrated to suppress acid gastric secretion in dogs. It is postulated that this is due to a local inhibitory effect since it does not inhibit histamine-induced hyperchlorhydria. Antihistamines[42] likewise reduce gastric secretion induced by stimulation of the antrum, but not the hyperacidity resulting from histamine and insulin-induced hypoglycemic hyperchlorhydria. Radiation[43,44] also has been used for suppression of the stomach juices, the effects lasting a year or more.

Tobacco[45-49] has been thought by some to increase acid gastric juice, but this has not been consistently reproducible. Most investigators are in agreement that smoking is deleterious to ulcer patients and that healing is delayed if peptic ulcer patients continue to smoke.[48]

The Role of Hormones

Gray[50] postulated the pituitary-adrenal axis theory of antral (hormonal) stimulation. Early reports implicated ACTH and corticosteroids[51-53] as secretagogues and ulcerogenic compounds. This has not been substantiated[54-57] in its entirety since the incidence of peptic ulceration with these compounds is not appreciably higher than that found in the general populace.[12] Sustained intravenous ACTH[56] with constant gastric suction in humans does not produce hyperchlorhydria or increased pepsinogen secretion. Increased urinary uropepsin resulting from ACTH stimulation is not associated with a concomitant rise in serum pepsinogen. Hirschowitz and his associates conclude from

this that the effect of the hormone is that of selective action on the kidney with increased excretion of the enzyme.

Peptic ulceration and hemorrhage[51] have been attributed to ACTH and corticosteroids in some instances so that the use of these substances in ulcer-prone people seems to carry a definite risk. Primary peptic ulceration[15] of the jejunum associated with islet cell tumors of the pancreas constitutes the Zollinger–Ellison syndrome. Since then peptic ulceration of the duodenum and stomach have been included in this syndrome. Multiple, adenomatosis with tumors of the pituitary, adrenal, thyroid and parathyroid glands have been reported as ulcerogenic.[14,16]

Heredity and Stress in Duodenal Ulcer

Eighty-five per cent of the population have either type O or type A blood, and Buckwalter[1] maintains that there is a statistically significant increase of type O patients with ulcer and a concomitant decrease in the remaining 3 blood groups. It has also been estimated that patients with type O are 35% more likely to develop peptic ulceration. This, coupled with the estimate that 10%[58] of the population will be suffering from this disease, emphasizes its frequency and probabilities. The frequency of ulcer in families[59] lends support to the hereditary aspect of this problem. Heredity predisposition must not be confused however with ulcer personality (diathesis).[5,60] There is no common denominator for a true ulcer personality, but emotional stress can affect gastric secretion and motility. It has been noted that anger, hostility, rebellion, anxiety, and panic are capable of stimulating a powerful gastric response (hyperemia, hypersecretion and hypermotility).[6,7,28,29,61]

Burns and Brain Tumors

The Curling ulcer, which is a duodenal ulcer attributed to burns,[17,18] has been thought to be due to some chemical or possibly a hemoconcentration. Intracranial tumors as described by Rokitansky[60] also have been thought to bear some relationship to duodenal ulcer. These phenomona point out the role of local tissue susceptibility in duodenal ulcer.

Principals of Medical Treatment

This discussion will be limited to the medical aspects of treatment.

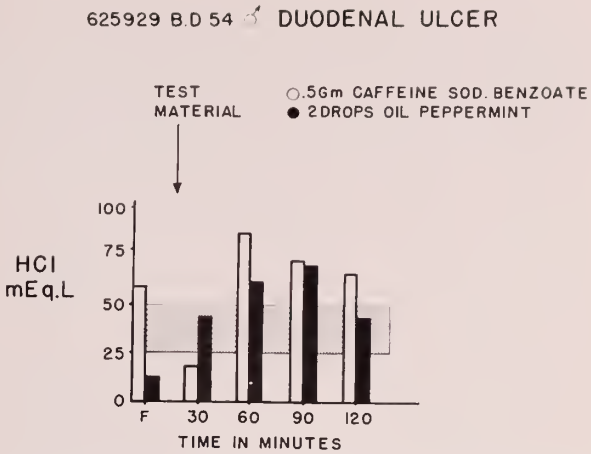

Fig. 4—Two drops of oil of peppermint dissolved in 200 cc. of distilled water produced a response in HCl very similar to that elicited with caffeine in a patient with duodenal ulcer.

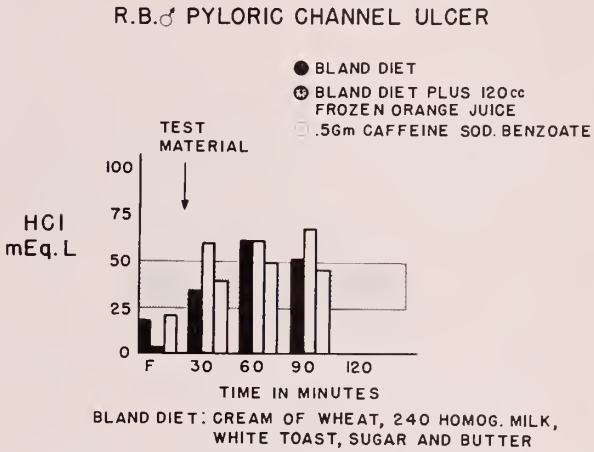

Fig. 5—The results of three separate gastric analyses on separate days in a patient with a pyloric channel ulcer. The test substances included a conventional "bland" meal, a second study included orange juice with the bland meal and a third study included caffeine. All three are capable of eliciting a sustained response.

At the present time no single etiologic agent has been proven in duodenal ulcer, but from the facts that are known, it is postulated that certain agents may precipitate an ulcer in a predisposed patient. The most consistent objective finding is hypersecretion. Neutralization of the acid gastric juice produces prompt relief of symptoms. Treatment therefore is designed to inhibit the secretory rate of the stomach and alkalinize the gastric contents. Aluminum hydroxide, magnesium trisilicate, calcium carbonate, and magnesium oxide are the most frequently used alkalies. The ideal antacid should be nonabsorbable, not constipating, and have adequate

acid neutralizing properties. It should be emphasized that the main objective is to use sufficient antacid to adequately neutralize the gastric contents.

Anticholinergics block only the cephalic phase of gastric secretion. Which of the various anticholinergic preparations is used depends on the enthusiasm of the physician. Sedatives and tranquilizers are useful for their overall effect, but should not supplant the primary objective of acid neutralization and suppression of secretion.

The diet program should be palatable and bland. In addition to the elimination of spices and condiments, such potent gastric secretory stimulants as coffee, tea, alcohol, peppermint flavoring, and orange juice should be deleted from the diet during the active treatment period. The foods selected are a matter of personal choice. Emphasis should be directed toward eating frequently at 1, 2, or 4-hour intervals with antacids between the feedings.

Certain drugs are considered ulcerogenic (caffeine, salicylates, phenylbutazone, Rauwolfia) and their use in susceptible patients should be tempered with caution. The same can be said for corticosteroids and ACTH. Anything in this category carries a calculated risk of precipitating an ulcer.

Primary endocrine tumors are beyond the scope of this paper and their treatment is surgical. Burns as the cause for peptic ulcer need only be mentioned. The same holds true for intracranial lesions.

Conclusions

Some of the factors concerned in the pathogenesis of duodenal ulcer have been discussed. The most consistent findings in duodenal ulcer are hypersecretion, hyperchlorhydria, and increased pepsinogen.

The fundamentals of treatment are based on the inhibition of gastric secretion and the neutralization of the acid gastric juice. The eradication of the contributory factors should be attempted insofar as possible.

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(Continued on page 702)

Dexamethasone in Short-Term Dermatological Conditions

By SHELDON M. BARNETT, M. D.

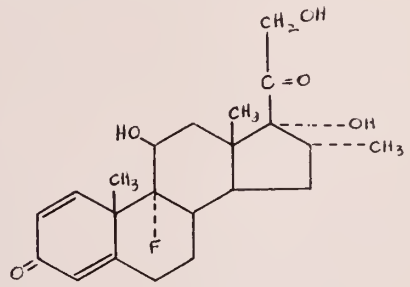
Milwaukee, Wisconsin

THE INTRODUCTION OF cortisone, the first of the therapeutically effective adrenocortical steroids, over a decade ago, marked the beginning of a new era in dermatology. For the first time the dermatologist had at his disposal a compound capable of controlling the majority of allergic and inflammatory cutaneous reactions regardless of their etiology. It thus became possible to suppress effectively many of the acute dermatitides; to control the symptomatology in chronic skin conditions, and to prolong the lives of and render more comfortable patients with more serious diseases, such as pemphigus and lupus erythematosus. It soon became evident, however, that cortisone was not the final answer because its beneficial effects were frequently accompanied by side effects of sufficient seriousness to necessitate discontinuation of treatment.[1, 2] Thus, a series of new corticosteroids was developed with the purpose of obtaining a compound with greater therapeutic potency and less side-effect potential. First came hydrocortisone with somewhat greater milligram potency. Following this, the first major breakthrough in the corticosteroid field occurred with the development of prednisone and prednisolone,[3, 4, 5] the first corticosteroids with greatly enhanced milligram potency and markedly diminished electrolyte disturbances. Minor structural modifications in the form of methylprednisolone and triamcinolone appeared subsequently.

Recently dexamethasone was added to the group. According to early reports, dexamethasone has approximately six times the potency of prednisone or prednisolone, and 30 times that of cortisone on a weight basis.[6, 7, 8] Certain of the side effects seen with earlier corticosteroids, especially electrolyte disturbances, appear to be greatly decreased in incidence with dexamethasone;[9, 10] the undesirable manifestations reported with hydroxylated steroids such as triamcinolone—muscle wasting, increased tendency to ecchymoses and abnormal weight loss—have not been seen to date with this new corticosteroid.

Chemistry

Dexamethasone (9-alpha-fluoro-16-alpha-methyl-11-beta, 17-alpha, 21-trihydroxy-1, 4-pregnadiene-3, 20-dione) is a synthetic analogue of prednisolone with the following structural formula:



Dexamethasone

In laboratory studies, dexamethasone proved to have a high degree of anti-inflammatory activity, approximately 6.5 times that of prednisone or prednisolone, and 30 to 40 times that of cortisone. Its mineralocorticoid activity appeared to be substantially lower than that of cortisone, prednisone or prednisolone; sodium or water retention was not seen at therapeutic dosages. Metabolic balance studies revealed that animals on controlled and limited protein intake will exhibit nitrogen loss on exceedingly high dosages. This phenomenon, however, has not been demonstrated on dosages within the therapeutic range.[11]

Dexamethasone (Deronil), used in this study, was made available through the courtesy of Harry V. Pifer, Jr., M.D., Clinical Research Division, Schering Corporation, Bloomfield, New Jersey.

Clinical Study

Nineteen patients with acute dermatological conditions, or acute exacerbations of long-standing conditions, were given dexamethasone tablets. The dosage regimen was essentially the same for all patients: 0.75 mg. four times a day, orally. Two patients were controlled with 0.75 mg. twice a day, while one required an initial dosage of 0.75 mg. every three hours for the first 18 hours; and in another, up to 1.5 mg. four times a day was necessary. These dosages were tapered down or discontinued as soon as the patient's condition permitted it.

Atopic Eczema

Eight patients with atopic eczema, including one case of lifelong duration and one with severe vesicular lesions, were given dexamethasone. Excellent or good improvement occurred in all eight of these cases. Improvement was reflected in prompt regression of lesions and relief from itching. Seven of these cases experienced no side effects; the eighth patient, however, complained of voracious appetite and marked gain in weight.

A Representative Case

S. M., female, 21 years of age, had atopic eczema of 20 years' duration. She had been given cortisone in 1950 with only fair results. She was placed on dexamethasone, 0.75 mg. four times a day.

The patient reported complete relief from itching within an hour. Lesions flattened out and resolved within two weeks. Since pruritus recurred when the drug was withheld, the patient was continued on maintenance therapy with dexamethasone.

She complained of voracious appetite and gained ten pounds during first month of therapy. After being placed on dextroamphetamine plus amobarbital (Dexamyl) concomitantly, she lost seven pounds. No other side effects were seen.

Severe Pruritus

Two patients with severe pruritus were controlled with dexamethasone. In one case a dexamethasone ointment prepared by us was used concomitantly and in the other perphenazine (Trilafon) 4 mg. four times a day, was given simultaneously. One patient experienced no side effects and the other showed slight weight gain.

Contact Dermatitis

Five cases of contact dermatitis involving various parts of the body cleared completely on dexamethasone therapy within one to three weeks. None of these patients experienced any side effects.

A Representative Case

R. D., a 35-year-old male had severe contact dermatitis of face due to shampoo. He was placed on dexamethasone, 0.75 mg. four times a day.

Lesions cleared completely within one week. There were no side effects.

Psoriasis

A patient with severe scalp psoriasis of six weeks' duration was given dexamethasone, 0.75 mg. four times a day, for one week without improvement. In view of the lack of results therapy was discontinued.

Cold Allergy

A very interesting case of cold allergy was treated with dexamethasone. This 55-year-old male exhibited urticaria and purpuric lesions involving the ear and penis as a sensitivity reaction to dampness and temperatures below 75 degrees F.; as a result he was unable to leave his house at temperatures below 75 degrees F. After being initially controlled with 1.5 mg. dexamethasone four times a day, the patient was placed on a maintenance regimen of 0.75 mg. four times a day. He continues under good control and shows no side effects.

Angioedema and Urticaria

One patient with angioedema and one with urticaria were successfully treated with dexamethasone. The patient with angioedema had received various steroids and a steroid-tranquilizer combination previously but escaped control in spite of these drugs. He was controlled within one week on dexamethasone. No side effects were seen in either of these patients.

Discussion

In the dermatological conditions described in this study, dexamethasone proved highly effective in doses approximately one-tenth of those generally employed with prednisolone. The absence of serious electrolyte disturbances and side effects peculiar to hydroxylated steroids, previously reported by other investigators, was confirmed. Some patients,

however, presented voracious appetites and undesirable weight gain. Like all corticosteroids, dexamethasone proves most effective when used judiciously in adequately diagnosed cases, after conservative measures have failed. These initial results suggest that while not replacing the established corticoids, prednisone and prednisolone, dexamethasone will prove a welcome addition to the corticosteroid arsenal.

Summary

1. Nineteen patients with various corticosteroid-responsive dermatological disorders were treated with dexamethasone (Deronil), a new adrenocortical steroid.
2. Dexamethasone proved effective in 18 out of 19 cases treated, in doses approximately one-tenth those generally employed with prednisone or prednisolone.
3. Two patients experienced severe weight gain and one moderate weight gain. No other steroid-induced side effects were seen during this preliminary study.
4. The same contraindications that apply to the older corticosteroids generally apply to dexamethasone; these include peptic ulcer, active tuberculosis, osteoporosis, and herpes simplex. In some cases the physicians must weigh the risk of possible side effects against the seriousness of the corticoid-responsive condition and the benefits anticipated with the steroid.

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ACUTE DISSECTING ANEURYSM OF THE AORTA. Surgical correction of dissecting aneurysm of the aorta is now possible. The exact diagnosis of this condition is therefore more important than ever. The histories of 11 patients who underwent surgery have been analyzed in order to identify retrospectively the symptoms and findings most valuable in establishing the diagnosis. The most important was a history of very severe pain which usually radiated to the back and frequently moved from its original location to another area; it was more severe than the pain of myocardial infarction and particularly significant in the absence of electrocardiographic abnormalities. Roentgenograms were of critical importance in 9 of the 11 cases, especially in one instance when the aortogram showed a double-barreled lumen. A difference in the peripheral pulses was present in 6 cases. Systolic murmur, abdominal bruit, and an abdominal mass occurred in less than half of the cases, but were helpful diagnostic points when they did occur. Four of the 11 patients survived surgery and did well after operation. Although the mortality in this series was high, the risks of allowing acute dissecting aneurysm to go untreated are so great that the authors advise prompt operation as soon as diagnosis is established.—JULIEN R. BECKWITH *et. al.*, A.M.A. Arch. Int. Med. 104:217–225 (Aug.) 1959.

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CLINICOPATHOLOGIC CONFERENCE

Guest Editors: D. B. CLAUDON, M. D., R. R. KOENIG, M. D., and G. RITCHIE, M. D.

Milwaukee, Wisconsin

CASE PRESENTATION*

The patient, a white woman 66 years old, was admitted to the hospital on January 21, 1959, with a chief complaint of diarrhea, which was accompanied by slight dyspnea on exertion and nausea. She had felt "fairly well" until November 1958, but had had vague gastrointestinal complaints since the summer of 1958. At the time of admission she was having 6 to 8 stools a day. In the few weeks preceding admission she developed warty lesions of the arms, hands, and chest, and complained specifically of abdominal discomfort, anorexia, and early satiety. She also suffered considerable itching, which was apparently generalized.

Inventory by systems revealed no additional symptoms except slight burning on urination, without frequency or urgency, and varicose veins of both legs.

Her past medical history revealed a hemorrhoidectomy 9 years before this admission, but no other relevant factors.

On physical examination she showed no great distress. Small keratotic lesions were present on the arms, hands, chest, and eyelids. The right thyroid lobe contained a nodule of indefinite size. Some dullness to percussion was found at the right lung base. The pulse was 88 per minute, and the blood pressure was 170/90 mm. Hg. Her abdomen was distended, and a mass, presumably liver, was easily palpable in her right upper abdominal quadrant.

Laboratory examination revealed: hemoglobin, 10.9 gm./100 ml.; microhematocrit 39%; leukocytes 7,700/cm. mm., with 65% segmented neutrophils and 35% lymphocytes. Erythrocyte sedimentation rate (Westergren) 31 mm. Prothrombin 38%; cholesterol 130 mg./100 cc.; urine was within normal limits. Serum iron was 16.7 mcg./100 cc.

Her temperature, 98.8 F., on admission, rose and fell irregularly throughout her hospital stay, with a maximum of 102 F.

A biopsy of her liver was suggested, but postponed indefinitely because of her low prothrombin, which did not exhibit sufficient response to vitamin K to permit the procedure.

On February 3, 1959, her thymol turbidity was 13 units and bromsulphalein retention was 16%. The thymol turbidity decreased throughout her stay, and 10 days before her death it was down to 4 units. Serum proteins varied from 6.34 to 5.52%, with a reversal of the albumin globulin ratio.

Her hemoglobin remained about the same throughout her stay, but on several occasions she exhibited leukocytosis (up to 20,250/cu. mm.) with up to 92% neutrophils. Her erythrocyte sedimentation rate rose to 55 mm., and then decreased to a low of 12 mm., one month before her death.

She had repeated x-ray studies.

Her hospital course following admission was irregular, with an overall gradual downhill trend. On February 14, 1959, she complained of pain in her chest; dullness to percussion and absent breath sounds were noted over her right lung field. At this time her abdominal distention was increased, and a fluid wave was present. Later on the same day she experienced severe respiratory distress, and was seen to be apprehensive, ashen gray, sweating, and dyspneic. Her blood pressure at this time was 90/70 mm. Hg., her pulse was 120/min., and respirations 28/min. Her electrocardiogram at this time was within normal limits, but subsequent tracings showed progressive changes suggestive, but not diagnostic, of myocardial infarction.

The administration of oxygen made her comfortable temporarily, but her tachycardia continued and she became cyanotic and developed slight edema of the right lower extremity. Her pain recurred on February 23, 1959, and her abdominal and pleural fluid increased gradually. On March 19, 1959, a right thoracentesis was done, withdrawing 1600 cc. of dark amber, blood-tinged fluid. She became more comfortable, but suddenly

* From Columbia Hospital, Milwaukee.

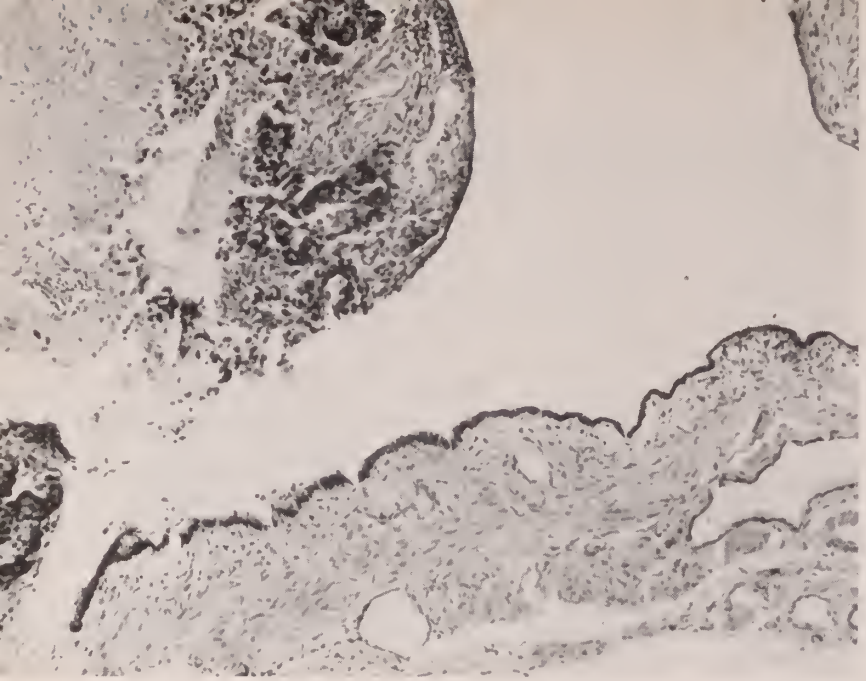


Fig. 1—Portion of cystic tumor in ovary. Note the epithelial lining on one surface and invasive neoplasm on the other. X 150

went into shock and died on March 22, 1959, after vomiting a large amount of coffee-ground material.

Discussion

Dr. H. W. Pohle: I will present some of the ways that this protocol could be interpreted, point out the interpretation which I think is most likely under the circumstances, and then invite all of you to take part. To this end, my first effort has been to set apart the facts of the case from the assumptions that are made; often we are surprised at the meagerness of the facts. Many statements put into the record are interpretations which may or may not actually be facts. We can agree that this was a 66-year-old white woman whose chief complaint was diarrhea. She also had secondary complaints of slight nausea and shortness of breath. The fact that she gave no history of vomiting or chest pains is important. There is very little information in the past medical history that will help us; she is said to have had "yellow jaundice," but that obviously is open to question. She had some treatment of varicose veins four years ago, apparently a medical attempt to control the varicosity without surgical intervention. This merits attention because it may have a bearing on our subsequent statements.

There were some important findings from the physical examination. She had multiple verrucoid skin lesions over her arms and eyelids. She was not acutely ill on admission; her skin was a little dry but she was not dehydrated; there was a questionable nodule in the right thyroid lobe. There was percussion dullness at the right base. The heart was of normal size and there were no murmurs. The apical rate was 88 and her blood pressure was 170/90.

Her abdomen was not tender, but it was slightly distended, with a greatly enlarged palpable liver. This liver was the striking abdominal finding, with a background question of some fluid in the abdomen. Bowel sounds were present. There was no edema of the extremities, and the peripheral pulses were present and equal. There were varicose veins of both legs. The physical findings are really quite meager: some skin lesions of questionable importance, a normal pulse, a high-pulse-pressure type of moderate hypertension, some percussion dullness at the right base, a huge nontender liver, bilateral varicose veins, and free fluid in the abdomen.

Laboratory findings showed that she had hypochromic anemia with a relatively normal hematocrit and a normal differential count. She had strikingly normal urine for a woman of 66 years; she had only 10 mg. of albumin per 100 cc., which is unusual in a person who has been moderately ill for three months. She had a reduced prothrombin time. Her blood sugar and nonprotein nitrogen were well within normal limits; her total protein was slightly decreased, with specific reversal of her albumin globulin ratio. Her blood cholesterol was 130 mg./100 cc., serum bilirubin was normal, the transaminase likewise was normal; thymol turbidity was elevated, alka-

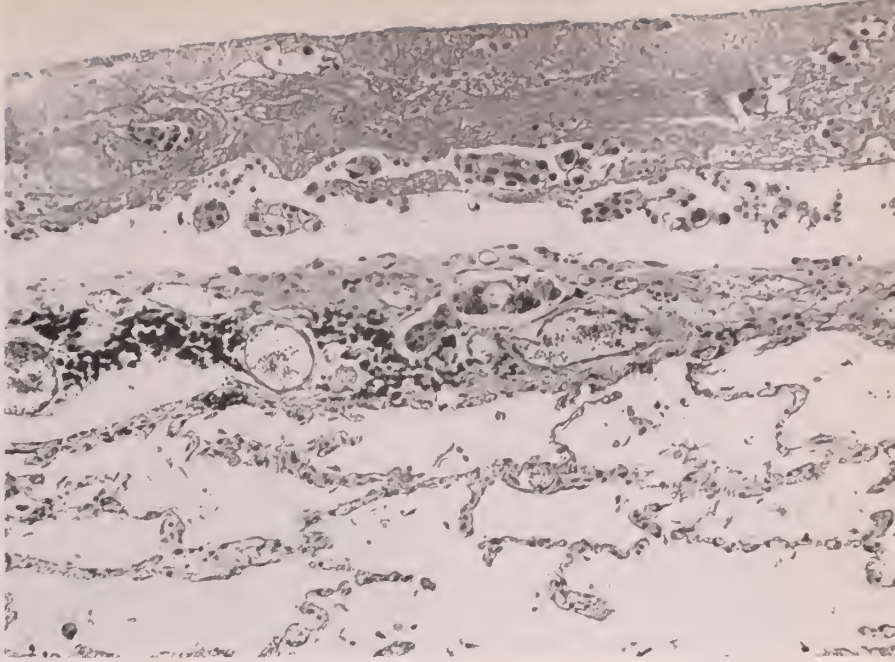


Fig. 2—Pleura with underlying lung tissue. Note the neoplastic cells in the pleura itself and in the inflammatory exudate. X 150

line phosphatase was normal and urine porphobilinogen was also normal.

The patient became ill in a relatively subtle way, and over a three-month period she became gradually incapacitated and entered the hospital because of diarrhea, but also because of nausea and some slight shortness of breath after exertion. On physical examination the predominant findings were those limited to the abdomen, with a huge liver, a question of right pleural effusion, and a moderate amount of abdominal fluid.

A primary liver disease should be considered.

Dr. W. J. Howland: Our x-ray studies on this patient in August, 1958, included a barium enema which showed severe diverticulosis of the sigmoid and the lower descending colon, but no evidence of diverticulitis. The liver shadow in these films did not show enlargement, and there was no displacement of the colon to indicate ascites. After admission in 1959, examination of the upper gastrointestinal tract revealed a small diaphragmatic hernia; otherwise she had a normal upper gastrointestinal tract. The intravenous pyelogram, shortly after this admission, showed normal excretory function on both sides. The liver shadow at this time appeared considerably enlarged. The kidneys were normal in size and their position and contour were good. On this examination it was noted also that there was diffuse opacity of the abdomen, very suggestive of ascites. There was some deformity of the bladder. A pressure deformity noted in this region is most likely to be caused by an enlarged uterus. The chest x-ray on admission showed that the patient was not able to take a deep breath, evidently because of the ascites and abdominal distention. The transverse heart size was at the upper limits of normal. There was increased density in the right base, the contour of which suggested the presence of free pleural effusion. Another chest film was made later in her hospital course, on March 14, which showed a great increase in pleural effusion; still another was made after thoracentesis showing that the effusion had disappeared, revealing some pulmonary infiltration suggestive of inflammatory disease or parenchymal infiltration.

Dr. K. A. Liefert: She first began to complain in May, 1958, of rather indefinite mid-epigastric pain, usually before meals or about two hours later; at times it had occurred at night. At that time she had x-ray studies of her stomach and gallbladder which were normal. At the time of her admission in August she still complained of vague abdominal pain. It was not until November that she complained of generalized itching involving the entire body. At this time a mass in the right upper quadrant was found, but it was not as large as reported here. I believed that this mass was the liver; Doctor Gorder proctoscoped her and found no lesion. He felt this mass and also believed it to be liver. Accordingly we did some liver function tests. Her serum bilirubin was normal, but her thymol turbidity was 9.9 units. Actually, she was admitted initially for biopsy of the liver.

She was given vitamin K, orally and parenterally, to raise her prothrombin, but there was no response so a biopsy of the liver could not be made.

Dr. H. W. Pohle: The hospital course was disappointing from the attending physician's standpoint. I believe she developed a change in the location of her chief illness, a change to the cardiorespiratory system, because on the 9th hospital day she had an attack of shortness of breath which must have been something of a surprise to those taking care of her. Then, on the 24th hospital day she developed substernal pain and went into shock. On the 32nd hospital day she developed some edema of her left leg. On the 57th hospital day it was thought that the predominant issue was a tremendous right pleural effusion, and 1600 cc. of fluid was removed. Two days later she died after vomiting a fairly large amount of coffee-ground material.

In going over the record, one gets the impression that she came in with a question of liver disease. There was added a cardiorespiratory complication which, as the days went by, took over the whole scene, and despite all this her liver got better, at least from a laboratory standpoint; then she died of cardiorespiratory disease, two months after admission. The laboratory tests simply substantiate that theory. There are some startling facts about this case. For instance, her sedimentation rate, which was rapid on admission, got more rapid for a time; then before she died it was down to 29. In other words, this was getting better. She did not develop the degree of anemia that one would have expected if this had been only liver disease. Her nonprotein nitrogen was only 29; it went up to 82, but subsequently came back to 45 before she died, which makes one even question the importance of extrarenal factors. She had a blood cholesterol of 130 which certainly does not point to obstructive liver disease. It may have been starvation; it may have been in part diarrhea. The phenolsulfonphthalein test showed 72% total output. The thymol turbidity improved somewhat and then, within the last three weeks of her illness, it came down to 4, which certainly does not point toward progressive gastrointestinal disease with the primary illness confined to the liver. The question is how to put all this together. There are several possible interpretations.

We could assume that this was gastrointestinal disease initially; that she had been put to bed for purpose of study; that she had developed phlebitis; that she then had had multiple pulmonary emboli which became the dominant issue; following this she died.

Notice that she had had only unilateral edema from the beginning. That suggests obstructive disease of the veins, but it could be old obstruction; in other words, she had trouble years ago and it is possible that as her protein declined, as the intraabdominal pressure increased, the first trouble would show up on the side where she had her maximum impairment of venous return. The alternative, of course, is that she had new phlebitis in the same leg. Another possible interpretation is that she had gastrointestinal disease, that she was put to bed, that she developed pneumonitis, that she developed pleurisy with effusion and died ultimately of pneumonia, which might or might not have been an overwhelming process. I do not think as much of that latter one because the fluid was not purulent and, in reading the protocol, I had the impression that there were rather dramatic periods when she had sudden onset of shortness of breath and shock and the other symptoms. She could have come in with gastrointestinal disease, then was put to bed and had myocardial infarction, then progressive myocardial failure with mounting pleural effusion and ascites, and died ultimately of circulatory insufficiency. I do not like that interpretation, because the edema was not dependent; it was confined to cavities. It is unusual for a person to have terminal heart failure without having sacral and ankle edema on both sides as dominant manifestations. A fourth possibility: she could have had some systemic disease of which liver impairment was an early sign, and as other systems were involved the manifestations there became dominant. Allergic vasculitis, periarteritis nodosa for instance, is notorious for the shift in the focus of the illness as time continues. This one I cannot prove or disprove. I am disappointed in the low degree of eosinophilia that she had. I am disappointed at the improvement in her sedimentation rate, if this was allergic vasculitis. Finally, she could have had initially a gastrointestinal disease which had started very subtly, which had taken her to the physician two or three times and then ended in his finding her with a large liver.

The secondary consequence of this illness became predominantly manifest in the cardiorespiratory system and led, ultimately, to her death with symptoms referable to this system. There are occasions when you can not say why you subscribe to an idea, but you are intrigued by it and you can not give it up. This explanation intrigued me the most. Any lesion which might have started in the gastrointestinal tract, such as, for example, an argentaffinoma, could have spread to her liver, could have given her a large liver with symptoms that brought her into the hospital, and could have gone on to involve the lungs. She could have had pulmonary thrombosis with unilateral signs. She might or might not have had concurrent thrombophlebitis with secondary pulmonary embolism, but she would not need this to develop finally enough pulmonary involvement and to die from that cause.

These are not, obviously, the only interpretations; however, these are some of them.

Dr. A. A. Holbrook: Are there any other questions?

Question: Was there any dietary history of significance?

Answer: There was no alcoholism, and because of the diarrhea she had limited her fruits and vegetables for some time.

Question: Was there a pelvic examination?

Answer: Pelvic and proctoscopic examinations were done in November, 1958, and no abnormality was found.

Question: What were the electrocardiographic findings?

Answer: Numerous cardiograms were taken, but no evidence of acute gross myocardial infarction was found and the changes were considered relatively insignificant.

Question: Was there abdominal pain early in the history?

Answer: There was.

Question: What about pulses in the lower extremities?

Answer: The pulsations in the lower extremities were normal.

Question: Did she run fever throughout her hospital stay?

Answer: There was fever, practically throughout the hospital stay, including periods of considerable "spiking."

Question: What was the serology?

Answer: The serology was negative for syphilis.

Dr. D. M. Willson: It seems that one might explore further the nature of the gastrointestinal disease involved. The significant thing that stands out is the laboratory evidence of diffuse hepato-cellular disease. In other words, it appears that there is something akin to cirrhosis present here as an underlying factor. When you try to figure a type of cirrhosis, you have no historical help in diet or alcoholism for a Laennec's type of cirrhosis, but that does not completely exclude this. Itching is presumably a little more common in cholangiolitic type of cirrhosis, but there is no evidence of that, unless you invoke the possibility that she may have had subclinical hepatitis and developed cirrhosis afterwards, but that is postulating something that was not diagnosed.

Going beyond that, you arrive at a positive point: that there has been an enormous enlargement of the liver from August until the time of admission to the hospital, as evidenced by the previous x-ray films. You can think in terms of carcinoma of the liver secondary to cirrhosis, and this can be either hepatoma or the bile-duct type of carcinoma. The presence of fluid in her right pleural cavity and the presence of the rapidly enlarging liver would fit in very well with a picture of malignant hepatic disease. And, then if you are thinking in terms of hepatoma you realize that it could have extended up into the diaphragm and caused the pleural effusion. Extension might also explain some of the pain and the nonspecific electrocardiographic changes. Similarly, extension could involve the lymphatic drainage of the left leg and pressure in the dome of the bladder seen in the intravenous pyelogram. It seems that someone was thinking at one time about the possibility of hemochromatosis as the cause of cirrhosis. There was a normal serum iron, so that does not seem very likely. An obvious thought, in retrospect, is that it was unfortunate that we could not put a needle into her liver to get a histologic picture. A biopsy would have probably given the true answer.

Dr. F. F. Rosenbaum: On reviewing the cardiograms, I find that there is some evidence of myocardial involvement; if there was a tumor, these changes might even be the result of myocardial metastasis.

Dr. G. C. Owen: What about the possibility of a primary neoplasm in the pelvis, in view of the distortion of the urinary bladder on the intravenous pyelogram?

Dr. J. E. Conley: I would like to suggest the possibility of Meigs' syndrome: primary carcinoma of the ovary with spread throughout the abdomen and chest. As I hear the case reviewed, it seems likely.

Dr. R. R. Koenig: At the autopsy, the abdominal cavity contained approximately five liters of turbid yellowish-green fluid. There were numerous fibrous peritoneal adhesions between the loops of the large and small intestines and numerous subserosal neoplastic nodules. The liver was not enlarged, but in fact was smaller than normal. However, the greater omentum was firm, rolled up, and infiltrated with tumor, thus producing a palpable abdominal mass. The right pleural cavity contained about 500 cc. of dark amber fluid and left pleural cavity was dry. Recent thrombi were identified in the arteries of both the right and left lungs, but these were most numerous on the right. In the upper left lobe, a 5 x 3 x 1 cm. abscess cavity was seen, just beneath the pleura. Greyish-white firm tumor was present in the hilum and subcapsular tissues of the spleen, and occasional metastatic lesions that measured up to 0.5 cm. in diameter were seen on the cut surfaces of the liver. The abdominal lymph nodes, especially in the celiac and pelvic regions appeared to be invaded extensively by metastatic tumor.

Examination of both ovaries showed that they were polycystic and contained tumor tissue similar to that seen in the rest of the abdominal cavity. The largest ovarian cyst measured 4 cm. in diameter. There was an obstruction at the neck of the uterus, producing retention of the uterine secretion and eliminating any possibility of clinical vaginal bleeding.

Histologically, the tumor within the ovaries was a papillary serous cystadenocarcinoma. All of the metastatic lesions had a similar histological pattern.

The right pleura was diffusely infiltrated with metastatic tumor nodules which explained the right pleural effusion. The anatomical diagnosis, therefore, was bilateral ovarian papillary serous cystadenocarcinoma with widespread abdominal and pleural metastasis.

The hepatic failure in this case was attributed to the few liver metastases and the physiological and chemical alterations produced by the generalized carcinomatosis and the pneumonitis. Histologically, the liver showed minimal chronic cholangiolitis and severe central zone congestion and atrophy, with associated acute anoxic necrosis.

Cultures from the left pleural abscess were positive for Diplococcus pneumoniae.

Dr. A. Holbrook: This could then be classified as a Meigs' syndrome.

Question: When you said that the omentum was rolled up, could you tell us a little more about what that means?

Dr. D. B. Claudon: He means by that, that we could unroll it. It was rolled up somewhat like a pancake and formed a sausage-shaped mass lying across the upper portion of the abdomen.

In answer to Doctor Willson's regret that there was no liver biopsy, I think in this instance a punch biopsy of the liver would not have aided us because there were only one or two small capsular metastases.

Question: Was there any involvement of the myocardium or pericardium by the tumor?

Doctor Koenig: The heart was of normal size and the only changes were those of moderately advanced arteriosclerotic disease. No tumor could be identified, either grossly or histologically.

Doctor Holbrook: The cardiographic changes were compatible with the plugging found in the pulmonary arterial system.

Question: Doctor Koenig speaks about the "cysts" of the ovaries; were they large enough to produce the demonstrable defect in the bladder cystogram?

Answer: Yes.

Ages One to Six—Getting-Ready Years

By O. R. CADE*
Madison, Wisconsin

LEARNING ABOUT good health practices begins long before Johnny and Susie set foot in school. It begins, in fact, while they are still infants and continues through the preschool years. Today an increasing number of physicians and parents, as well as teachers, are taking a second look at the way this learning occurs and are cooperating to make it as meaningful as possible. The aim, of course, is to give all of our children a good start in school.

Back of this "second look" is the realization that children do not suddenly evolve out of thin air at six years of age to start school. Each child is a distinct, unique individual who has experienced life in his own terms for six years prior to the momentous occasion. How the child has grown and developed during this period will influence the way in which he relates to his initial experiences in school—and may indeed influence ever after his attitude toward formal education.

Our knowledge of exactly how children learn is quite limited but observations of the process suggest that some of our present educational practices might well be reconsidered. For example, by law a child is ready for school when he is six years old. Yet six year olds vary a great deal in their ability to function well in a school situation. They do have certain common growth characteristics but the qualitative character and rate at which individual facets of growth have occurred vary. Obvious examples include physical size, motor skills, social skills, and emotional maturity. Other differences are shown in terms of attitudes and meanings, past experiences and heritage.

We recognize that children are continually growing and that the on-going process of growth is occasionally marked by periods of stasis and regression. Growth occurs in terms of the total individual even though all of its component facets do not develop at an even pace. Adjustments are constantly taking place within the individual child and between children and parents as growth takes place. How this adjustment is made affects both the quality and rate of growth. It is especially important to recognize as a child starts school that his proficiency in dealing with new situations is influenced by his total, cumulative life experience. A wide range of constructive past experience provides a broader basis for dealing constructively with a wider range of new experience. The foundations for all of future learning are being developed during the preschool or getting-ready years.

These observations are especially important to people working in the health field, who are concerned with the development of health attitudes and practices. Physicians have a unique opportunity to work with children and parents long before school time arrives.

A physician might well consider with parents: What is involved from a learning standpoint in a youngster's first visit to the doctor—whether this be at the age of three months or three years? What learning takes place between the parent and child prior to this visit? What learning takes place at the office? What takes place after the visit? What takes place before, during, and after an immunization procedure?

We might also ask what takes place during these years in relation to the learning of eating habits, dental hygiene, personal cleanliness, covering coughs—sneezes, well child medical supervision, and a number of other questions. As Dr. Georgia B. Perkins of U.S. Children's Bureau has stated, "The status of the school-age child's health is greatly dependent on his health prior to the time he entered school. Unless we know about that previous period, we really do not know the child . . . ." She also asked if, "we know enough about how this child reacts to stress, how he responds to authority, what kind of support or problems he experiences at home.

* Director of the Division of School Health, Wisconsin State Board of Health.

. . . . . Do we know anything about what he thinks we are doing to or with or for him?"[1]

We have attempted to raise what we believe to be some basic questions. Unfortunately, we do not have any ready answers but some activities show promise. For example, school visits for preschoolers, readiness for school programs involving teacher—nurse—parent discussions, visits to physicians and dentists, child study groups, and home—school reading projects are tangible efforts to maintain and promote health. We know that when youngsters reach school age they are different, distinct individuals; they have many well established attitudes, concepts, and feelings, and that these children do respond differently to any experience including formal education. We are convinced that much more can be learned through work with parents of preschoolers and preschool children themselves which will point the way toward giving every six year old Johnny and Susie a good start in school.

REFERENCES

1. Perkins, Georgia B.: Improving the health of children of school age, Children 5:169–174 (Oct.) 1958.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Manual for Emergency Blood Procurement**—Copies available from Civil Defense Health Services, Wisconsin State Board of Health, 1 West Wilson Street, Madison 2, Wisconsin.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service plan.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Occupational Health, A Guide for Medical and Nursing Personnel**—General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
14. **The Income Tax for Wisconsin Physicians**—A brochure, newly revised, containing a review of the state and federal income tax laws as they apply to the physicians of Wisconsin.
15. **The Doctor's Role in Adoptions**—A reprint of three *Wisconsin Medical Journal* articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Health—A Force For Peace

Editor's Note: Presented below is o speciol communication submitted by Melvin R. Loird, U. S. Representative from Wisconsin, ot the request of the Editor.

At the request of the President of the United States, I recently participated in one of the most dramatic demonstrations of international good will in action that the world has ever known.

The occasion was the World Health Assembly in Geneva, the yearly meeting of delegates from ninety member nations of the World Health Organization. The people whom I met there, the information they presented on the health problems of their people, and the spirit in which they sought to solve these problems, alone and together, spoke eloquently of the force that international health can be for international peace. I returned with a renewed conviction that working together is the key to living together, with recognition of individual and cultural differences, and with respect for each other's point of view.

Unfolded there before us in Geneva was a moving spectacle of man's endless quest for freedom from hunger, freedom from disease, freedom from tragic disability and premature death.

It seemed not to matter that our problems in the United States are different from those of many nations that are not so fully developed as we: we are concerned with the control of cancer, but our sister nation is concerned with the control of cholera; we search for ways to prevent arteriosclerosis, but our brother nation seeks basic sanitation; we try to extend a life span of three score years and ten, but our neighbor to the southeast merely tries to live to be two-score; we emphasize neurological diseases and mental health and the rheumatic disorders in our health programs, but our neighbor to the southwest emphasizes schistosomiasis and filariasis and onchocerciasis.

The important thing is that health issues tend to accent similarities and minimize differences, just as they tend to obliterate both political differences and geographical boundaries. It is important, too, that in world health programs, we in the United States have a great deal to receive as well as a great deal to give. Thus health provides the nations of the world with a forum in which they can meet together and work together with unity of purpose and as equals.

Two important points stand out from the WHO meeting.

The first point is that by its conduct, by its leadership, and by the position it took on the important issues before the Assembly, the United States Delegation clearly advanced the prestige of our nation and achieved signal victories for the many nations that are allied in the cause of freedom. The World Health Organization is not a political forum. But it is an international agency, and it was perfectly clear to me that on several major issues, the position of the United States was supported not only by those nations that are customarily with us in matters of principle, but also by a great many nations that are just beginning to throw off the shackles of disease and of economic and social underdevelopment, and to emerge as productive and participating members of the family of nations. The delegates from the Soviet Union and other nations allied with them suffered one setback after another. I shall never forget the image of the Soviet Delegate, standing before the full Assembly, and decrying the unwillingness of underdeveloped countries to take advantage of the consultation, technical aid, equipment, and other assistance offered by the Soviet Union.

The second point I wish to emphasize is the effective use that is made of United States dollars in the work of the World Health Organization. As a member of the Committee on Appropriations for health, education, and welfare activities of our federal government, I have good reason to know the financing of health programs and the kinds of progress that are purchased by the investment of dollars in the health field. I want to make it clear that the total financing of the World Health Organization will be slightly less than $17 million in 1960. The United States assessment will be 30% of the total budget.

A major part of the increase over the 1959 budget of WHO is represented by $500,000 for the start of a program of international medical research, proposed by the United States. The inclusion of this medical research item in the 1960 budget was a major accomplishment of the United States Delegation in Geneva. Here again the Russian Delegation opposed the start of this program of international medical research and exchange.

I want to state my deep conviction that it is hard to think of ways in which so few American dollars could purchase so much that is intimately related to our national and international aspirations. On returning to the United States from this 12th yearly meeting of representatives of nations united to improve people's health, I have renewed confidence in the explicit and implicit values to be derived from international working collaboration. It is my deep conviction that the activity of the World Health Organization will be broadened and strengthened in the years ahead, and that at the same time the United States should strengthen its own unilateral activities in the health field, including international health programs. This type of people-to-people activity in the health area on the part of the United States will go far in keeping peace.—MELVIN R. LAIRD.

The President's Page . . .

Notes on the A.M.A. Interim Session, Dallas, Texas, November 30-December 4, 1959

DALLAS . . . . . . A young, brash, boisterous beautiful, rapidly growing city, flexing its financial, social and industrial muscles—taking on all comers in competition. Truly Dallas is one of the great cities of the world but not nearly at its peak. Its one great advantage—the yet prevalent enthusiasm of pioneering, a lost quality that has led to the social decay of some of our Eastern cities.

THE HOUSE OF DELEGATES . . . . . Not many controversial issues—much misinterpretation over report of Atlantic City Meeting relative to free-choice of physician. The House clarified its intent by stating that although it was in the American tradition for a patient to choose between a medical plan involving no free choice of physician and one that did allow him free choice, such did not mean that the medical profession approved of closed panel plans. A note of nostalgia and regret—the long, illustrious and dedicated career of Doctor William Stovall, as a delegate from Wisconsin, came to an end with this Session. No one who ever served in the House has served medicine with greater diligence, integrity or distinction, and few have served it as well. We say to you, Doctor Stovall—"Hail, but not farewell." Wisconsin medicine will continue to need your sound wisdom and advice, and it is pleasing that A.M.A. will continue to receive your services as a member of the important Council on Constitution and Bylaws.

THE EXHIBITS . . . . The technical exhibits—flamboyant, colorful and appealing as usual. I noted a great many commercial exhibits that had little or no direct relation to the practice of medicine. The usual number of excellent scientific displays were shown depicting the swift advances in medicine.

(continued)

DR. LOUIS ORR . . . President of the American Medical Association. In his report to the House, stated "A citizen cannot, simply because he is a physician, pass on to others his political responsibilities." "A physician cannot, if he values this nation's high standard of medical care, divert his gaze from the social, economic and political issues which affect the practice of medicine."

SENATE MAJORITY LEADER LYNDON JOHNSON FROM TEXAS (of course) . He told the House of Delegates that the health of America had become one of the world's richest prizes, one coveted by other nations. "We have inspired the creation of the outer shell of freedom," he noted. "If we leave that shell to stand hollow and empty, communism will fill it, and the form will become both meaningless and a mockery."

Senator Johnson further stated, "that communism today is seeking to persuade the world that its system offers the best hope for liberation from poverty, ignorance, and disease." He concluded by saying, "A more vigorous communism can only be matched by a more vigorous America."

SPEAKER OF THE HOUSE SAM RAYBURNE FROM TEXAS (of course) . Scholarly, kindly, but firm and determined—"There are enough people in Congress to stop socialized medicine," he stated, "But, sometimes there must be an alternative." "That is when we have to sit down and talk to you."

IN GENERAL . . . . . Wisconsin doctors can be proud of the respect and esteem with which our Society is held by our sister State Societies. Wisconsin medicine has had many "firsts." We are looked upon as leaders.

As a truly educational experience, the A.M.A. Sessions leave something to be desired. Because of their number, nature and size, it is next to impossible to participate in many of the opportunities for learning that are offered. However, to really get the feel of the pulse of the vibrant, dynamic force for good that *is* American medicine, attendance at an American Medical Association Convention is essential.

William B. Weldenkampf M.D.

Traveling Doctors

It is just plain human nature that people always want to try something "new."

It was this matter of boundless yearning for something "new" that made the traveling doctors so highly successful in the days before radio and television leaped continental distances with their patent medicine advertisements.

The steady hometown general practitioner always had his due respect from patients, but let a circuit-riding "doc" come to town and people flocked in fascination for miles around.

Some of these doctors who crissed-crossed the country in earlier days were authentic M.D.'s. Many were frauds, as slick as the snake oil they sold. But all had their following, full of faith and hope.

One such traveling doctor (it is not known whether he was an M.D. or not) was particularly popular in Southern Wisconsin around the turn of the century.

Somewhat immodestly, he proclaimed in a local Stoughton newspaper advertisement: "I will be at the Hutson House for one day only to cure all serious diseases as well as mild ones such as skin eruptions and sores. I have 17,500 cases in my case book.—Dr. J. O. Brewster"

According to accounts, Doctor Brewster was "a tall, bearded man who inspired confidence in most sufferers at first sight." He followed the sun. In the winter months his touring practice took him to the southern states, and in summer he worked his way through the Middle West and northern United States.

For his one-day stand in Stoughton, Doctor Brewster chose the aforementioned Hutson House, which has now become the Hotel Kegonsa. He undoubtedly created a stir among townspeople for in those days before radio and television the discussion of individual illnesses, complete with all symptoms, was a common form of entertainment.

One of Doctor Brewster's old patients recalled the visit. The 10-year-old patient was taken to the "famous" doctor by his parents because he was suffering from what his own physician described as "consumption."

SECTION ON MEDICAL HISTORY

Doctor Brewster's examination was, needless to say, very swift; there were many, many people in line. But he agreed with his unknown colleague that "consumption" was clearly the ailment. Then he added that it would be soon fatal unless some big brown pills, known as "Doctor Brewster's Consumptive Cure" were taken immediately and steadily. The little boy's parents purchased many dollar's worth right then and there.

The good doctor went on to another patient, a woman. A quick inspection convinced him (and her) that she had a total of 25 different diseases. All might be possibly fatal unless his medication was taken. The frightened female purchased enough medicine, it is said, "to cover a table top."

In fact, she bought so much medicine that the touched Doctor Brewster presented her with his picture. Somehow the medicine didn't seem to help her, and, disillusioned, she gave the photograph to the parents of the little 10-year-old boy.

His father and mother, at least, seemed satisfied and they loved to recall how Doctor Brewster had snatched their son from death's door.

The term "death's door" was a popular and universal one in those days.

Testimonials in patent medicine advertisements always included it: "Before taking your tonic I was at death's door. Two bottles pulled me through."

Local newspapers used the term in their Personals columns: "Mr. and Mrs. John Sharp of Forest City, Iowa, are visiting the latter's brother, Torval Mathison, who is lying at death's door on South Street."

The Hutson House in Stoughton was the favorite stopping place for traveling doctors.

"A famous healer whose remarkable cures had startled people in the East will be at the Hutson House on May 26 for one day only to cure everything," read one ad.

But a caption on the bottom warned that the doctor was highly ethical: married women were to bring their husbands with them or there would be no treatment.

THE MEDICAL FORUM

STATE AFFAIRS

PHARMACY

President-elect Speaks

Addressing a Rock County Pharmaceutical Society in November, Doctor E. D. Sorenson, president-elect of SMS, stressed: "It's time we got together."

The two greatest responsibilities of both medical and pharmaceutical professions are professional competence and public service, he said.

"It is time we got together in the Legislature," Doctor Sorenson continued, "in our communities and before the public to expose this outlandish fraud (cult healing and quackery) and pool our efforts to convince the public of the truth of science and falsehood of cultism."

He called upon the two professions to help one another explaining the true facts about the cost of drugs and medical care. For example, he related, the cost of prescriptions has gone up only 26 per cent since 1946 as compared with 39 per cent for the cost of living.

He warned that unless the two professions obtain public understanding of the facts the federal government might step in with Forand-type legislation.

LEGISLATION

U. W. Hospital Bill

Moving quickly on the Governor's office proposal to change admission policies at the University Hospitals, the Assembly this month passed unanimously bill 981, A.

The bill implements portions of the Governor's report:

1.) The Orthopedic Hospital for Children is made a part of Wisconsin General Hospital; admissions are on the same basis as those to Wisconsin General.

2.) Authorization given for outpatient housing facilities for public patients treated at Wisconsin General. Parents and guardians of minors may use the facilities as well.

3.) Recipients of categorical attendance (i.e. public assistance, aid the blind) may be certified by the county judge with the cost shared on a fifty-fifty basis between county and state.

4.) Quota system knocked out which, until now, limited counties to two admissions per 1,000 population with state and county sharing the cost.

5.) The state will now pay the entire cost of care, including transportation, of state-at-large patients who have no legal settlement.

PRESIDENT-ELECT SORENSON
"It's time we got together."

6.) Authority given to establish room rates and ancillary service charges at Wisconsin General as at any other hospital.

The SMS supported the bill inasmuch as the major concern has been the lack of adequate teaching material for U.W. Medical School. The bill, if it becomes law, would aid in this.

TRAFFIC SAFETY

Governor Answers SMS

Governor Gaylord Nelson has replied favorably to the proposal of Doctor Dayton Hinke, chairman of the SMS Division of Safe Transportation, that all state-owned motor vehicles should use seat belts, partly to set an example for Wisconsin citizenry.

"On the basis of the research results cited by you", said Governor Nelson, "confirmed and advanced by many reputable organizations, I deem it proper for the State of Wisconsin to exercise leadership in the use of these life-saving devices."

"I am requesting Mr. Nusbaum, Commissioner of the Department of Administration, to study this situation", he continued, "and to inform me what cost would be involved if all state departments operating state-owned vehicles were requested to specify that all replacement vehicles be equipped with seat belts."

APPOINTMENTS

Board of Public Welfare

The State Board of Public Welfare will undertake a study of the entire county institutional system.

Aim of the study is to explore "the benefits that can be realized through the effective coordination of institutions operated by state and county, as well as community facilities for mentally ill and aged."

A Citizen's Advisory Committee, appointed to carry out the study includes three physicians: R. E. Housner, M. D., Richland Center; Charles Landis, M. D., Milwaukee; Carl N. Neupert, M. D., Madison.

Other committee members: Arthur J. Altmeyer, Madison; F. R. Bachhuber, Wausau; Joseph E. Baldwin, Milwaukee; Helen L. Bunge, Madison; Stanley J. Cardinal, D. D. S., Madison; Sen. Peter P. Carr, Janesville; Assemblyman Isaac Coggs, Milwaukee; Mrs. Thomas Catlin, Neenah; C. L. Greiber, Madison; Harry Hamilton, Madison; Ersel F. LaMasters, Beloit; Reverend James R. Love, Madison; Calvin Mills, Owen; William Rhyme, Portage; The Reverend Joseph P. Springob, Milwaukee;

BLUE SHIELD–BLUE CROSS–MEDICAL SOCIETY RELATIONSHIPS

Presented by A. W. HILKER, M. D.

Wisconsin Physicians Service is the duly approved Blue Shield plan of the State Medical Society of Wisconsin. It operates throughout the state with the exception of Milwaukee County. In Milwaukee County a separate Blue Shield plan, known as Surgical Care, was set up under the jurisdiction of the Medical Society of Milwaukee County.

Prior to August, 1957, Blue Cross of Wisconsin acted as sales representative of both WPS and Surgical Care, each plan offering its services within its respective area of operation. Disagreements between WPS and Blue Cross arose as to sales practices and reimbursement formulas following a request by Blue Cross for renegotiation of the agency contract. Blue Cross later served notice of termination of its agency contract with WPS as of July 31, 1957.

Blue Cross of Wisconsin organized a wholly-owned stock accident and health insurance company, Health Insurance Corporation, to write general medical care and hospital care insurance in Wisconsin. Later, Blue Cross entered into an arrangement with Surgical Care of Milwaukee County to represent it as sales agent not only in Milwaukee County but throughout the entire state of Wisconsin.

On June 4, 1958, the Council of the State Medical Society unanimously authorized WPS to enter the hospital insurance field so as to protect the programs of WPS by offering combined surgical-medical and hospital expense coverages to the public. This entry into the hospital insurance field was with the approval of the Insurance Department of Wisconsin.

At about the same time, the Council of the State Medical Society of Wisconsin became concerned about the expansion of Surgical Care outside Milwaukee County in league with Blue Cross and in competition elsewhere in the state with the state's own plan, WPS. A Council resolution adopted on September 13, 1958, stated that "the activity of Surgical Care is approved for Milwaukee County only; that it has no approval to enter into other areas of the state, and if it does, it is doing so in violation of Council action."

The House of Delegates of the State Medical Society of Wisconsin, in special session on September 27–28, 1958, adopted a resolution supporting the Council action and directed Surgical Care to confine its operations to within Milwaukee County.

Thus far, Surgical Care has refused to abide by the mandates of the Council and of the House of Delegates of the State Medical Society of Wisconsin. It continues to operate in conjunction with Blue Cross throughout the state, and on several occasions aspersions have been made by sales representatives of Surgical Care against the financial soundness of WPS to the point where public confidence in the State Medical Society's plan is being questioned in some places.

It is regrettable that the Blue Shield plan operated by the Milwaukee County Medical Society should be openly competing with the Blue Shield plan of the State Medical Society outside Milwaukee County. It was never intended that the two Blue Shield plans should compete. Each was to have its own area of operation.

Ever since the dissociation, the State Society, through its Commission on Medical Care Plans, its Council and its officers, has made continuing efforts to resolve these problems, without success to date.

Dr. Hilker, authorized by the Executive Committee, SMS Commission on Medical Care Plans, of which he is a member, made the above statement at the November meeting of the North Central Medical Conference, Minneapolis, Nov. 22, 1959.

A. J. Thelen, Madison; Eugene Toepel, La Crosse; G. I. Wallace, Madison.

CONFERENCE

North Central Meeting

In late November Wisconsin was represented at a Minneapolis meeting of the North Central Medical Conference.

The Conference, which meets annually for an exchange of information on the practice of medicine, is made up of the officers and councilors of state societies in Wisconsin, Minnesota, Iowa, Nebraska, North and South Dakota.

The Wisconsin contingent, led by Dr. William B. Hildebrand, included: Drs. E. D. Sorenson, Elkhorn, A. A. Quisling, Madison, L. O. Simenstad, Osceola, A. W. Hilker, Eau Claire, V. E. Ekbald, Superior, and J. W. Fons, W. J. Egan, G. S. Kilkenny, all of Milwaukee.

The Conference covered such subjects as political action, grievance committees, medico-legal problems, the Forand Bill and "Blue" plan relationships with medical societies.

(See Dr. Hilker's statement in box)

Dr. Quisling gave a comprehensive report on Wisconsin legislative activities.

"Within my memory," said Dr. Quisling refering to the 1959 legislature (now in session again), "there has never been a more demanding and significant session. It was a year of repeated assaults upon the integrity of medicine."

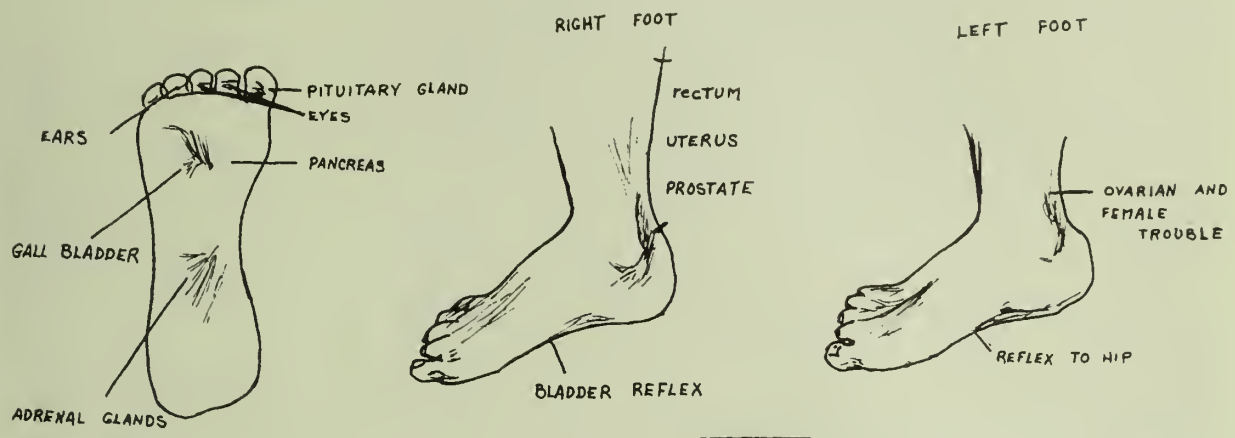
He spelled out the many attempts of "confident" chiropractors and naturapaths to ram through favorable legislation; the series of bills that would have virtually assured a heavy increase in unwarranted malpractice actions.

"Fortunately," continued Dr. Quisling, "the final results of the first session were quite highly successful for medicine."

"But I must emphasize that this accomplishment should be no cause for complacency," he said.

Dr. Quisling closed by urging "constant and continuing contact" with legislators—and supporting them for public office—as the only practical way to obtain "sound decisions on matters effecting medicine and public health."

Dr. Simenstad took office as president of the Conference, a post he will hold until next November.



REFLEXOLOGY

Playing Footsie

Recently literature has been circulated in Wisconsin that frankly smells of someone playing footsie with reflexology.

The practice, outlawed in this state, is a takeoff on the principles of William H. Fitzgerald, M. D., who introduced "Zone or Pressure therapy" in the early 1920's.

Dr. Fitzgerald's concept: apply pressure to specific zones of the body to control pain and make the body more resistant to painful impulses. He urged the medical world to make further investigations.

A Mrs. Eunice D. (Ingham) Stopfel, Rochester, N. Y., has since capitalized on Dr. Fitzgerald's discoveries, developing the "Ingham Reflex Method of Compression Massage."

A reflexologist deals only with the nerve endings in the patient's foot. According to the cult, a diseased or ill organ gives off impurities (calcium) which travel downward, via the blood stream, to lodge in the foot.

The foot is divided into zones, each corresponding with another part of the body. For example, if the base of the right big toe is sensitive to pressure, ergo, the source of the physical ailment is the right side of the back of the neck.

Treatment usually consists of rubbing the feet and using a vibrator to "relax the muscles." Then pressure is applied to the feet with the reflexologist's thumb.

"They press forcibly on with the thumb until the patient screams," says one account.

The theory: pressure breaks up the calcium deposits, sends them back to the blood stream to be eliminated as body wastes. With the calcium gone, the pressured area is no longer tender, the afflicted organ is set right again.

Physicians are asked to report any interception of literature within the state to SMS. (see example on this page)

MATERNAL MORTALITY

Green Bay Gathering

Only one Wisconsin mother in 3,000 dies in childbirth these days, but physicians and hospital personnel, striving to make the odds even safer, gathered in Green Bay early this month for a regional Maternal Mortality Institute.

The meeting was one of a series conducted by the SMS, State Board of Health, and the Wisconsin Academy of General Practice, in various sections of the state. It drew some 150 people, including 81 physicians, an attendance figure which was considered very good. Altogether, 14 hospitals were represented.

Said Doctor Thomas A. Leonard, chairman of the SMS Maternal Mortality Study Committee: "While we experience only 30–35 true obstetrical deaths per year, as compared to over 90,000 births, we feel that everything we can do to save a single mother is worth all the time and effort of our study."

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STATE AFFAIRS

HOSPITALS

UW Visiting Hours

Longer visiting hours have been announced at the University of Wisconsin Hospitals because out of town visitors have found the present schedule difficult to meet.

The new hours are: medical, surgical and obstetric sections 11 a.m. to 8 p.m. daily; pediatrics open at all times; psychiatry 1B, 2 to 4 p.m. Sunday, Wednesday, Friday and Saturday, and 7 to 8 p.m. Wednesday; and psychiatry 2B, 2 to 4 p.m. Sunday, Tuesday, Thursday and Saturday, and 7 to 8 p.m. Wednesday.

GP

Heaviest Patient Load

According to recent studies, the general practitioner carries the heaviest national average patient load: 18.5 individuals per day.

The pediatrician has the next highest: 17.1. Average number of daily patient visits for other types of practice includes 13.1 for E.N.T., 12.7 for obstetrics and/or gynecology, and 12.1 for internal medicine.

ACCIDENTS

Industrial Commission Study

Recently, the State Industrial Commission released a six months report on compensable accidents within the state.

Total number of cases from January to June, 1959 was 16,475. There were 534 cases labeled "strain of over-exertion"; 410 involved handling objects.

Of the 410, 196 were caused by lifting or lowering, 27 by pushing or pulling, and 187—general handling.

These figures, the Wisconsin Council of Safety pointed out, call for the need of more power equipment for lifting and handling, instructions on how to lift and good house-keeping.

Of 527 injuries resulting by fall or slip, 370 were on working surfaces. Of these, 122 were injured by slipping, 18 by falling on the same level, 62 by falling into excavations or pits, 6 falling from moving vehicle or equipment.

The Commission reported that 224 injuries occurred by tripping, sliding or rolling on materials not handled by anyone.

STATE BOARD OF HEALTH, meeting in mid November, posed for formal picture during deliberations. Seated (l. to r.): W. T. Clark, M. D., Janesville; John S. Hillingsworth, D. D. S., Sheboygan; Elizabeth Baldwin, M. D., Marshfield; S. L. Henke, M. D., Eau Claire. Standing (l. to r.): E. H. Jorris, M. D., Madison; Edward N. Vig, M. D., Viroqua; James P. Conway, M. D., Milwaukee; J. C. Griffith, M. D., Milwaukee; Carl N. Neupert, Madison.

INSURANCE

AMA Regional Conference

Late in November several Wisconsin physicians attended a Minneapolis meeting of the AMA Regional Conference on Insurance and Prepayment Plans.

Representatives of state medical societies, industry, farm and labor groups, came from a six-state area: Iowa, Minnesota, Nebraska, North and South Dakota, and Wisconsin.

Those from Wisconsin were Drs. William B. Hildebrand, E. D. Sorenson, A. A. Quisling, W. J. Egan, and G. S. Kilkenny.

The group ranged over regional opinion on the present state of health insurance coverage including benefits, rates and effectiveness to the public.

To compete with closed panel type plans it was suggested that voluntary "Blue" plans provide expanded benefits, particularly to give better coverage in diagnostic areas.

AMA representatives reviewed progress in the Midwest on health insurance for the aged.

Their report made attending SMS members a little proud. WPS, it was revealed. was the only Blue plan in Wisconsin offering hospital-surgical-medical coverage to all ages over 65, and the only one of two plans in six Midwest states offering nursing home benefits. The other one: Iowa.

Robert Froehlke, Stevens Point, vice president of Hardware Mutuals, urged that physicians recognize their citizen's obligations in the problems of aging, health insurance and indigent care.

He wanted cooperation between the Blue plans and private carriers, and suggested periodic meetings.

Both Froehlke and Dr. Hildebrand spoke out for actual cost sharing by the patient.

Said Dr. Hildebrand: "I believe it highly important that the patient share in the cost of surgical-medical-hospital insurance by the use of deductible or co-insurance, or both."

"Only through this method," said Dr. Hildebrand, "can the total cost of health insurance be held within the reach of the public."

STATE AFFAIRS

LEGISLATION

Public Health Resolution

During the initial 1959 legislative session Joint Resolution 78, A was introduced to "conduct a study during the 1959–61 interim of the local public health service in order to outline the role of the local government health committee and their relationship to the State Board of Health and to submit recommended revisions of Wisconsin laws designed to improve local public health services."

Such a study and remedial legislation had long been urged by the State Medical Society.

The study called for by the resolution (subsequently included in Joint Resolution 94, S) is to be conducted by the Legislative Council.

A subcommittee of the council has now been appointed. From the Senate: Casimir Kendziorski (D) Milwaukee, Henry W. Maier (D) Milwaukee, Peter P. Carr (R) Janesville, Howard W. Cameron (D) Rice Lake.

From the Assembly: Robert F. Barabe (D) Mellen, Isaac N. Coggs (D) Milwaukee, Marty Larsen (D) Milwaukee, Elmer L. Genzmer (R) Mayville, Christ M. Stauffer (R) Monticello, Walter Ireland (R) Kohler, Roy Naleid (D) Racine.

From the public: (citizens who have demonstrated knowledge and interest in problems of public health): Conrad Shearer, Jr., Kenosha attorney; Robert Nuckles, Madison, assistant to the mayor; H. G. Grewe, D. D. S., Eau Claire; and Carl Mohr, Green Bay, deputy health commissioner.

The subcommittee which has opened its hearings, has listed several specific questions on public health facilities.

Some of these:

1. What new pattern of community health services is needed for Wisconsin, since many of the old proposals have been disregarded?

2.) Why have the statutes, permitting establishment of full time county, city-county, and multiple county health departments failed, since only in Eau Claire county has one of these units been established?

FIVE OF EIGHT 50-year veteran doctors honored at Christmas dinner—meeting of St. Mary's (Milwaukee) medical staff and hospital administrator, Sister Hermine. Seated (l. to r.): A. J. Weber, M. D. (date licensed in Wisconsin: 1907); T. H. Rolfs, M. D. (1902); T. A. Judge, M. D. (1909). Standing (l. to r.): E. W. Miller, M. D. (Illinois, 1907; Wisconsin, 1912); H. O. McMahon, M. D. (Michigan, 1904; Wisconsin, 1919). Unable to attend: A. T. Holbrook, M. D. (1897); J. W. Kleinboehl, M. D. (1902), and A. Rheineck, M. D. (1910).

3.) What methods of financing local public health service are most feasible, particularly in view of widespread governmental budget difficulties?

4.) Where is coordination of public health service on the local level most needed; how can it be best effected?

5.) Would there be a significant problem in staffing full time local health departments? What vacancies would be most difficult to fill?

6.) Is a multiple county health department favorable?

7.) What should be the role of local units in relation to the public health needs of the state?

8.) What should be the role of the State Board of Health in administering public service on the local level?

9.) What should be the role of voluntary health groups, such as public health councils, in the local public health picture?

The committee is authorized to report its findings and recommendations to the legislative council not later than November 1, 1960.

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PREMARITAL LAW CHANGES

Recently, changes in the Wisconsin premarital law were enacted. The new requirements to become effective January 1, 1960, that are of significance to the physician and his patients are:

1. Both male and female applicants are required to have a thorough examination for venereal disease including a wasserman or other standard test for syphilis. (The previous law did not require a physical examination of the female.)
2. The physician's certifications for the physical and blood examinations have been combined into one certificate. (Formerly separate certificates for the physical and the blood examinations were required.) The new certificate is to be worded as follows:

PHYSICIAN'S CERTIFICATE

Required by Section 245.06 (d), Wisconsin Statutes

I, _____, being a Physician, legally licensed
(Name of physician)
to practice in the State of _____, do certify that I have on _____ ____, 19____ made a thorough examination of _____ for, and believe such person to be free
(Name of person)
from, all venereal disease; and I do certify that such person was given the Wasserman or other standard blood test for syphilis at _____ from blood taken by _____
(Name and address of laboratory)
on _____, ____, 19____ and that the result of such test was negative.

Dated at _____, _____, this ____ day of _____, 19____.

_____
(Signature of physician)

_____
(P. O. address)

Void after 20 days from date of examination by physician.

Booklets of the new certificate form can be purchased from:

H. Niedecken Company
511 North Water Street, Milwaukee

or

H. C. Miller Company
224 East Chicago Street, Milwaukee

In many counties, the county clerk will furnish the certificate upon physician's request. Pending the obtainment of a supply of these certificates it is suggested that the physician copy the form included in this notice for his immediate needs.

In amending the premarital law an error occurred that resulted in the law making reference to a 15-day and a 20-day period within which the marriage applicant has to obtain his examinations, prior to applying at the county clerk's office for a license. Revisor's Bill Number 684, S. is in process of correcting the error, and it is anticipated that the 20-day period will prevail. It is also anticipated that the county clerk will abide by the oldest of either the blood or the physical examination dates and not by the date when the physician signs the form, when he determines whether the completed certificate falls within the 20-day period.

MEETINGS

Editorial Board

Last month, members of the Editorial Board of *Wisconsin Medical Journal* gathered in Madison to review the continuing operations of that publication.

The board approved of a proposal by the AMA Specialty Journals to supply the WMJ, for possible use, some 50 abstracts per month of articles now appearing in the various journals.

Members also agreed that there should be more papers on diagnosis and that state physicians should be encouraged to submit more papers than they are doing now.

These submissions, the Board stressed, need not necessarily be the unusual or unique type, but rather common every day occurences which may have a particular twist that would be of interest to other physicians.

Doctor Etheldred Schafer, Madison, president of the Wisconsin Society of Pathologists was present to discuss the publication of Clinicopathologic Conference articles.

The Board felt very strongly that such articles should appear in the *Journal*, and a coordinated arrangement for securing such articles was agreed upon.

Doctor R. S. Baldwin, Marshfield, the *Journal's* medical editor, reported some good news from the State Medical Journal Advertising Bureau conference recently held in Chicago.

In an evaluation of 34 state journals, *Wisconsin Medical Journal* scored an 88. This was just below the seven highest ranking journals with 90 and over.

Members present: Drs. R. S. Baldwin, Victor S. Falk, Garrett A. Cooper, David W. Ovitt, and David N. Goldstein.

NEWS BRIEFS

Footprints

Writing in *Hospitals*, J. Edgar Hoover, FBI Chief, urged that to properly identify infants a "brief footprinting course . . . in all nurses training schools" be required. While experts are needed to read the footprints, said he, instructions by hospital personnel would increase legibility for identification purposes "where law enforcement has an interest."

CONQUEST AT BARGAIN PRICES

By ANDREW MASHBERG

Of The Health News Institute

What percentage of your patients complain to you that the price of medicine is too high? If it's about four out of every ten you're right at the national average.

But, before you decide to agree with these patients, it might be a good idea to take a good long look at the prescription prices to determine why they cost what they do, and whether they really are too expensive.

According to one publication, the average prescription in 1958 cost $3.08. But, of course, this doesn't really tell the story of prescription prices. This same prescription . . . or one costing $5 or $10 . . . often helps physicians cure an illness that twenty or thirty years ago would have cost $500 or $1,000. Maybe it was responsible for the patient's survival.

The story of pneumonia is a good case in point. Thirty years ago, according to a survey conducted in Philadelphia, a case of lobar pneumonia meant five weeks in the hospital, out-of-pocket costs of at least $400, plus lost earnings during hospitalization and convalescense. Total costs: About $1,000. And one out of every three patients died. Today the average case of lobar pneumonia lasts less than two weeks, does not usually require hospitalization, and only one out of 26 victims dies. Total cost: About $15 for penicillin or $30 for one of the broad spectrum antibiotics, plus the physician's fee.

Mastoiditis is another good example. In 1940, Children's Hospital in Boston reported 305 cases of mastoid abscess. For most of these stricken youngters, little more than palliative treatment could be administered to ease the agony while they were waiting for a difficult and painful operation which cost up to $1,000, and often meant partial loss of hearing. Today, many younger doctors have never seen a mastoid abscess. The "expensive" antibiotics permit physicians to control the infection for a cost of $15 to $20, and eliminate the need for surgery.

Not only has the cost of illness dropped since the introduction of the modern drugs, but our people spend little more of their disposable income today for medicines than they did twenty or even thirty years ago. In 1929, Americans spent an average of .73 per cent of after-tax income on drugs and sundries. In 1957, that figure had increased to only one per cent despite an increase in the average price of prescriptions from 85 cents in 1929 to $2.90 in 1957.

Nor has the cost of prescriptions during the postwar inflationary spiral taken as heavy a bite from the American paycheck as many other necessities. Bureau of Labor statistics indicate that medicine costs have risen by only 26 per cent since 1946, compared with 41 per cent for food, 45 per cent for rent and 39 per cent for the cost of living index in general.

The clearest indication of the relative decrease in prescription prices can be determined from an examination of the so-called "real price" of prescriptions. That is, the amount of time that the average American has to work to pay for his average-priced prescription.

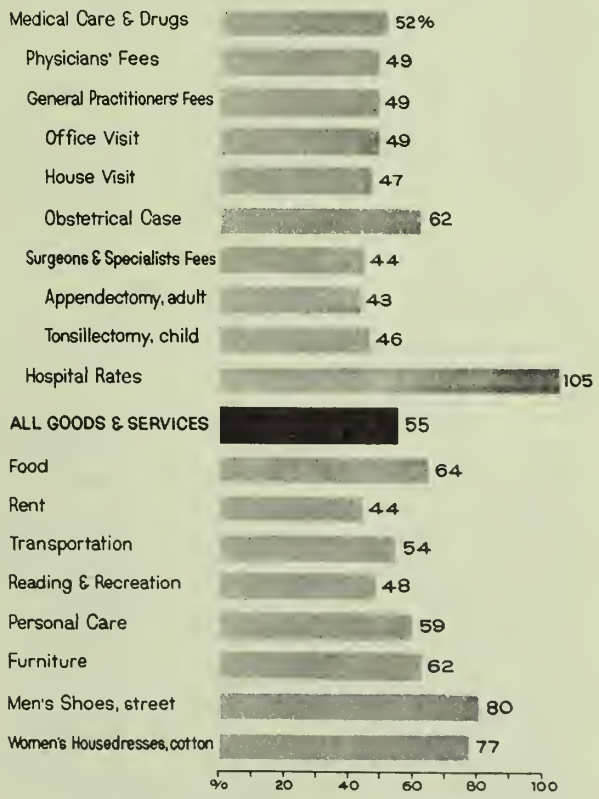
In 1929, as we have noted, the average price for a prescription was 85 cents. To pay for this, it took one hour and thirty-one minutes of working time at prevailing wages. In 1958, despite the fact that the average prescription cost $3.08, it took only one hour and 26 minutes of working time to pay for it.

One of the main reasons for the increases in prescription costs is the steadily rising percentage of sales devoted to research. Out of every dollar received by pharmaceutical manufacturers from sales of medicine in 1958, more than nine cents was plowed back into research and development of new

Chart III

PERCENTAGE OF ONE WEEK'S WAGES REQUIRED IN 1957

to purchase the same amount of medical care and other items which could be purchased with ONE WEEK'S WAGES IN 1935-1939



Source: U.S. Bureau of Labor Statistics

Bureau of Medical Economic Research
American Medical Association

drugs. In 1958, alone, the pharmaceutical industry invested more than $170,000,000 in research. This represents an increase of 50 per cent over the $110,000,000 spent on research only two years earlier, in 1956.

One drug corporation executive estimates that "about three years of intensive investigation usually is required before a drug can be judged effective and released for public usage. Furthermore, only one new compound in 500 to 1,000 ever reaches the drug store . . . odds which no professional gambler would ever take."

More than 8,000 different compounds were screened by one company in the search for isoniazid. Another company studied 34,000 potential antibiotics and 8,000 chemicals in the search for better healing agents. Of the 42,000 products studied, just six were considered worthy of clinical testing.

And, not all of thet products which prove clinically valuable turn out to be commercial successes. The story of the multi-million dollar search for pneumonia vaccine which panned out just as the sulfa drugs came along is one example. Another is the story of the synthesis of cortisone from ox bile, which cost millions of dollars to accomplish and which was on the market for only six months before a cheaper process of synthesizing the steroid was discovered by a competitor.

Both the successes and failures of research have contributed to the increased price of new medicines. But, both the successes and failures of research have also contributed to the better health and well being of Americans.

In balance, the cost of medicines must be weighed against our increasing life expectancy; the virtual disappearance of childhood diseases; the plummeting death rate from influenza, pneumonia and tuberculosis; and the future hope for relief from today's great killers, cancer and heart disease.

AUXILIARY

"In Appreciation"

Troubled by the ever-increasing need to support new and existing medical schools throughout the nation, the SMS Auxiliary is reminding Wisconsin physicians to send a contribution to the American Medical Education Foundation.

"Perhaps the Christmas season would be a good time to refresh the doctors' minds on this program", said Mrs. G. A. Behnke, Kaukauna, president.

Her suggestion is to have one physician's family pay another physician for medical service rendered by sending a contribution to the AMEF in the name of the physician whose services were required.

The Auxiliary has such "In Appreciation" forms available. They may be obtained from the Auxiliary secretary at SMS.

MEETINGS

Council on Scientific Work

Meeting last month in Madison the Council on Scientific Work completed the program for the 1960 annual meeting.

Arrangements included scheduling of surgical motion pictures as accompaniments to lectures for the May 5th portion of the program. A full schedule of scientific exhibits was approved.

The Council considered in detail the special service of the SMS Foundation which provides lecturers to county medical societies. Rules were established to reimburse speakers' expenses which may cover any physician or lecturer on a related scientific subject. However, speakers on nonscientific subjects would not receive reimbursement.

The council also held a joint meeting with the Editorial Board to review problems dealing with the *Wisconsin Medical Journal.*

Members present were: Drs. M. F. Huth, M. C. F. Lindert, R. B. Larsen, R. W. Farnsworth, J. Z. Bowers.

SCHOOL HEALTH

Division Meets

Meeting in December, the Division on School Health reviewed a report on an iodine study undertaken in cooperation with a committee of the State Board of Health.

The report surveyed the iodine tablet program in Wisconsin and other methods of preventing goiter in the state.

The report concluded that from the available evidence most persons are able to get their minimum requirements through the use of iodized salt.

It recommended that local health committees discontinue dispensing tablets when present supplies are exhausted.

At the same time it suggested an intensive campaign to educate the public on the use of iodized salt and suggested that physicians, among others, stress such use.

The Division recommended the report for study and approval by the State Board of Health and the House of Delegates.

The Division also voted to set up an athletic injuries display at the SMS annual meeting with demonstrations on prophylactic taping.

Members present: Drs. L. M. Simonson, Sheboygan, chairman, E. E. Bertolaet, West Allis, J. C. H. Russell, Fort Atkinson, E. C. Hoyer, Beaver Dam, J. G. Heisel, Superior, J. W. Harkness, Wauwatosa, Amy Louise Hunter, Madison.

POISON CONTROL

Kenosha

OLympic 4–5311, Poison Information Center, Kenosha Hospital, Kenosha.

Madison

ALpine 6–6811, University Hospitals Poison Information Center, Madison.

Milwaukee

DIvision 4–7100, Poison Control Center, Children's Hospital, Milwaukee

NEWS BRIEFS

Interstate

At a recent Chicago convention of the Interstate Postgraduate Medical Association, Doctor R. G. Arveson, Frederic, was re-elected to the board of trustees. Doctor Nels Hill, Madison, was elected Fellow of the organization.

Minutes of Special Council Meeting Madison, June 21, 1959

1. Call to Order and Roll Call

The Council was called to order by Chairman Fox at 11:15 a.m. on Sunday, June 21, 1959, at Society headquarters in Madison.

Councilors present were Doctors Lokvam, Hill, Houghton, Dessloch, Blanchard, Kief, Fox, Bell, Mason, Frank, Ekblad, Egan, Fons, Galasinski, and Kilkenny. Officers: President Hildebrand, President-elect Sorenson, and Vice Speaker McGreane. Members of the Committee on Public Policy: Doctors Quisling, Quackenbush, Goldstein, and Enzer. Members of the Commission on Hospital Relations and Medical Education: Doctors Gearhart, Beatty, Boren, Picard, McCann, McDonell, Overman, and Hirschboeck; Mr. Lloyd Hughes in place of Doctor Bowers. Specialty representatives: Doctors Habbe, Haukohl, Bookhamer, Garnett, Wylde, McClung; Attorney A. E. LaFrance. Staff and consultants: Messrs. Crownhart, Thayer, Koenig, Reynolds, and Neese; Mrs. Anderson; Misses Rendall and Pyre; Attorneys Murphy and Gavin.

2. Bill 129, A.—Hospitals and the Practice of Medicine

The Council was brought up to date by Doctor Quisling and others on the status of this proposed legislation in the Legislature itself and in negotiations with hospital and specialty representatives. It was hoped that the Assembly would withhold action in view of this meeting and the Hospital Association meeting scheduled the following weekend, with the possibility of an agreed substitute being offered.

Mr. Gavin was asked to review the latest substitute for the original bill, which was drafted on June 18 by Doctors Quisling, Hildebrand, Habbe, Enzer, Haukohl, and Birge; and Attorneys LaFrance, representing radiology and pathology, Murphy and Gavin representing the Medical Society, and McCormack representing the Wisconsin Hospital Association. This proposal, to which the drafters were not committed, was advanced as a possible suggestion for legislation on the basis that it would be supplemented and implemented by a code of physician-hospital relations, to be developed.

Mr. Gavin reviewed the annotated June 18 draft and compared it with the present law, with Bill 129, A. as amended, and with an earlier (June 1) draft which had been sent to the Council with the qualification that portions of it were unacceptable to hospital people and others to the medical profession. Mr. LaFrance then presented his revision dated June 12 of the so-called "Whitewater draft" of May 15, and the strong objection to the naming of certain specialists with whom hospitals may contract under specified circumstances. He reasoned that they are physicians and should be designated as such. Mr. Gavin then explained the several areas where the Whitewater draft was felt to be inadequate, and the reasons why it seemed necessary to specifically name the physician specialists with whom hospitals may contract to provide certain consulting services.

A long period of open discussion followed, concluding with the statement by Mr. LaFrance in response to a direct question that the only remaining objection of the specialty groups to the June 18 draft was naming the specialists.

The Council then went into executive session for further discussion and action, Doctor Quisling and Mr. LaFrance remaining. Doctor Quisling said the Public Policy Committee recommended that the Council approve the June 18 draft in principle, subject to further editing to incorporate some suggestions raised in the presentation and discussion.

Doctor Dessloch spoke for opposition of Bill 129, A. or any substitute. Doctor Egan also questioned its necessity. Others felt that a substitute must be prepared for proposals permitting corporate practice and fee splitting, and other objectionable situations.

Doctors Kilkenny–Blanchard moved to approve the June 18 draft in principle. Doctors Frank–Ekblad offered an amendment which would eliminate the naming of specialists and substitute wording to the effect that any physician may contract with a hospital to act as a consultant only, and to be consulted only upon the request of another physician. The amendment was lost, but assurance was given that attempts would be made to reword the objectionable provision if adequate safeguards could be found. The original motion was passed, Doctor Dessloch voting in the negative.

3. Bill 907, A.

Mr. Gavin gave a status report of this bill, submitted by the Governor's office, which would give the Insurance Department some regulation over the "Blue plans." He said that Blue Cross had just offered a substitute, which had not yet been seen. The bill was scheduled for hearing the following Wednesday.

Doctor Dessloch said that the Commission on Medical Care Plans did not object to the final draft of the Governor's bill. Doctor Egan questioned the Commission's jurisdiction in this matter, and reported that the Milwaukee County Board of Directors was opposed to it.

4. Adjournment

The meeting adjourned at 3:45 p. m.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M. D.
Chairman of the Council

Minutes of Special Council Meeting with Wisconsin Hospital Association Representatives Madison, July 12, 1959

The meeting was called to order by Dr. James C. Fox, chairman of the Council, at 11:00 a. m. on Sunday, July 12, 1959, at the State Medical Society in Madison.

The following councilors were present: Drs. W. D. James, L. H. Lokvam, N. A. Hill, J. H. Houghton, E. M. Dessloch, P. B. Blanchard, J. C. Fox, J. M. Bell, R. W. Mason, R. C. Frank, J. P. Conway, W. J. Egan, R. E. Galasinski, G. S. Kilkenny, W. P. Curran, and Past President H. E. Kasten. Officers and other physicians present: President Hildebrand, President-elect Sorenson, Vice Speaker McGreane; Drs. W. D. Stovall and L. O. Simenstad, delegates to the American Medical Association; Dr. A. A. Quisling, chairman, Committee on Public Policy; Drs. Norbert Enzer, George Nadeau, E. C. Quackenbush, committee members, and Dr. S. R. Beatty. Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Doran, Reynolds, and Neese; Misses Rendall and Pyre; Attorneys Murphy and Gavin; counsel for the State Medical Society, and Attorney A. E. LaFrance, representing the Wisconsin Societies of Pathologists and Radiologists.

Mr. Karl York, president of the Wisconsin Hospital Association, introduced the following representatives of that organization: R. J. Platte, Second Vice President, Clintonville; R. M. Jones, Treasurer, Waukesha; N. E. Hanshus, Executive Secretary, Eau Claire; Msgr. Edmund J. Goebel, Milwaukee; Margaret Schloemer, Elkhorn; S. K. Hummel, Milwaukee; Warren Von Ehren, Green Bay; Robert C. Haskins, Stoughton, trustees; Riley McDavid, Kenosha, Legislative Committee chairman, and Orville M. Pick, Prairie du Sac, committee member; Attorneys Robert McCormack and R. W. Peterson.

Following introductory remarks, there was general discussion of Bill 129, A. and substitute amendments 1, A. (proposed by the Wisconsin Hospital Association) and 2, A. (proposed by the State Medical Society). Discussion continued until luncheon recess at 1:00 p. m., when a committee from each organization was named to meet during the recess and try to arrive at the areas of agreement and disagreement.

When the meeting reconvened at 2:00 p. m., Mr. Gavin was asked to read substitute amendment 2, A. section by section, and as he proceeded the joint committee proposed its recommendations, as follows:

"Section 1. 147.225 Fee splitting between physicians and others. (1) Authorized agreements. Any physician who renders any medical or surgical service or assistance whatever, or gives any medical, surgical or any similar advice or assistance whatever to any patient, physician, corporation, or to any other institution or organization of any kind, including a hospital, for which a charge is made to such patient receiving such service, advice or assistance, shall render an individual statement or account of his charges therefor directly to such patient, distinct and separate from any statement or account by any physician or other person, who has rendered or who may render any medical, surgical or any similar service whatever, or who has given or may give any medical, surgical or similar advice or assistance to such patient, physician, corporation, or to any other institution or organization of any kind, including a hospital."

After discussion, the above section was accepted.

"(2) Physician partnerships permitted. Notwithstanding any other provision in this section, it is lawful for two or more physicians, who have entered into a bona fide partnership for the practice of medicine, to render a single bill for such services in the name of such partnership."

After discussion, the above paragraph was accepted.

"(3) Contract exceptions; terms. Notwithstanding any other provision in this section, when a hospital, with the initial and periodic approval of its medical staff, considers that it is in the public interest, it is lawful for a physician to contract with a hospital to provide consultation services for attending physicians, as herein provided. Any treatment by such a consultant shall be in his capacity as a private practitioner; his relationship to the patient shall be governed accordingly; and such treatment shall be rendered only at the request of the attending physician, except that a physician specializing in pathology, physical medicine or radiology may include the treatment of referred cases in his contract with a hospital."

At this point a recommendation of the joint committee was introduced, that the phrase, "with the initial and periodic approval" be changed to "with the recommendation" of its medical staff . . .

Following discussion, it was concluded that the paragraph should commence as follows: "Notwithstanding any other provision in this section, when a hospital and its medical staff considers that it is in the public interest, . . ."

Mr. Gavin continued: "Such contract shall: (a) Require such physician to be a member of or acceptable to the medical staff of such hospital."

There was no objection to section (a).

"Such contract shall: (b) Not create the relationship between hospital and physician of employer-employe."

The joint committee recommended that provision be made in this section for continuation of pension or annuity programs for those physicians now under contracts with hospitals which might conflict in some respect, were this bill to become law.

It was suggested that the attorneys draft such a provision for consideration later in the meeting.

"Such contract shall: (c) Permit such physician to exercise his professional judgment without supervision or interference by such hospital, and provide that the professional responsibility of physician to patient shall remain as though the dealings were direct between them."

Mr. LaFrance proposed that the phrase following the word "hospital" be deleted as unnecessary language in the law. Following brief discussion, this suggestion was accepted.

"Such contract shall: (d) Establish the remuneration of the physician on any basis other than a salary or a division of net receipts."

The joint committee reported that it had been unable to reach agreement on this section, the hospital representatives wishing to delete it entirely. Considerable discussion followed, concluding with a poll of the voting representatives of each organization present on the question of concluding the section with the word "salary." The motion was carried.

"Such contract shall: (e) If agreeable to the parties, permit the collection by the hospital of the remuneration for such medical services and the rendition of a single statement by the hospital to the patient; provided that the statement names the physician who rendered the professional service and indicates that the charge, where such is the case, includes both the medical and hospital charges."

The joint committee reported alternate recommendations: either (1) conclude this section with the words "rendered the professional service"; or (2) substitute for section (e) as written in substitute amendment 2, A. the following language from substitute amendment 1, A.: "Such hospitals are authorized to charge the patient for services rendered by such physicians; provided, that the statement to the patient shall indicate that the costs of the services of such physicians, who shall be designated by name, are included in the departmental charges."

After discussion, the following language was agreed upon for section (e): "If agreeable to the contracting parties, such hospitals are authorized to charge the patient for services rendered by such physicians; provided, that the statement to the patient shall indicate that the services of such physicians, who shall be designated by name, are included in the departmental charges."

Mr. Gavin continued: "(4) Definitions. As used in this section: (a) 'Hospital' means an institution providing 24-hour continuous service to patients confined therein which is primarily engaged in providing facilities for diagnostic and therapeutic services for the surgical and medical diagnosis, treatment and care, of injured or sick persons, by or under the supervision of a professional staff of physicians and surgeons, and which is not, other than incidentally, a place of rest for the aged, for drug addicts, for alcoholics, or a nursing home. Such hospitals may charge patients directly for the services of their employe nurses, nonphysician anesthetists, and for medical assistants, other than physicians or dentists, and may engage on a salary basis interns and residents who are participating in an accredited training program under the supervision of the medical staff, and persons with a temporary educational certificate issued under s. 147.151."

Following discussion, this definition was accepted with substitution of the word "primarily" for the phrase "other than incidentally" in reference to places of rest, etc.

"(b) 'Physician' means an individual holding an unlimited license to practice medicine and surgery in Wisconsin."

This definition was accepted.

"Section 2. This act shall take effect January 1, 1961."

Before acting to accept this effective date, Messrs. McCormack and Murphy reported their recommended phrasing of the addition to paragraph (3) (b) of Section 1: "excepting only that any contract for deferred compensation, including but not limited to an annuity, in force on the effective date hereof, shall not be modified or abrogated by the force of any provision of this subsection." A motion to accept this clause was carried, followed by a motion to accept the effective date of January 1, 1961.

Finally, the group agreed to preparation of a new substitute amendment incorporating the revisions jointly accepted in this meeting, and to the release of a statement to that effect.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M. D.
Chairman of the Council

Minutes of Council Meeting
Land O'Lakes, July 24–25, 1959

1. Call to Order and Roll Call

The Council was called to order by Chairman Fox at 2:15 p. m. on Friday, July 24, 1959, at King's Gateway, Land O'Lakes, Wisconsin.

Councilors present were Doctors James, Lokvam, Hill, Houghton, Blanchard, Kief, Fox, Bell, Mason, Frank, Ekblad, Conway, Egan, Fons, Galasinski, Kilkenny, and Curran. Officers: President Hildebrand, President-elect Sorenson, Vice Speaker McGreane; Doctors Arveson, chairman emeritus; Simenstad and Bernhart, AMA Delegates. Staff and consultants: Messrs. Crownhart, Thayer, Toser, Gill, and Murphy (Saturday only); Misses Cordts, Moran, and Pyre.

2. New Business

These items of new business were introduced by councilors for consideration at the foot of the agenda:

Doctor Egan asked for an explanation of the organization of the State Society and the responsibilities of councilors.

Doctor Frank requested an expression of opinion from individual Council members on what action might be taken concerning a series of television programs being promoted by a group of limited licensees.

Doctor Conway asked for a report of the stability of Wisconsin Physicians Service.

3. Social Security Poll

The House of Delegates in May had adopted a resolution requiring a poll of the Society's membership on the subject of Social Security, the reference committee report suggesting that such poll include certain qualifying information. No assignment was made by the House on conducting the poll, and consequently the advice of the Council as to its character, the framing of questions, etc., was requested.

Several councilors spoke of the need to "educate" the members as to what they are voting for, both in advance of and accompanying the poll. Doctor Bell suggested county or district meetings with presentation and discussion of all the facts and implications.

On motion of Doctors Kief–Conway, carried, the chair was asked to appoint a three-member committee with power to develop the poll and to act, with the qualification that the material first be sent the Council for general approval.

4. Oath of Office; Adoption and Administration

On motion of Doctors Houghton–Hill, carried, the following oath of office was adopted by the Council:

"I (name) solemnly swear that I shall carry out to the best of my ability the duties of the office of the State Medical Society of Wisconsin to which I have been elected. I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to the task of bringing increasingly improved medical care within the reach of every citizen. I shall uphold the Constitution of the United States of America and of the State of Wisconsin, the Constitution and Bylaws of the American Medical Association, and the Constitution and Bylaws of the State Medical Society of Wisconsin at all times. I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. To these duties and obligations I pledge myself, so help me, God."

The oath was then administered by Chairman Fox to all elected councilors and officers present, and henceforth will be taken upon induction into office.

5. Certificate of Election

On motion of Doctors Curran–Hill, carried, the Council adopted a certificate of election in the form of an individually prepared scroll containing the following text, with appropriate variations to fit the office:

"I, (name), Chairman of the Council of this Society, do hereby certify that (name), of (city), was on the (date) duly elected by the House of Delegates a member of the Council from the (blank) Councilor District for the term of three years, ending in (month and year), and having duly taken his oath of office as prescribed by the Council, is hereby declared an incumbent of such office." (Signed by the chairman and sealed by the secretary.)

6. New Membership Certificate

It had been proposed that a new membership certificate be designed which would incorporate the basic purposes of the State Medical Society as stated in the Constitution. Such a design was presented to the Council, with the proposal that in addition to the annual issuance of printed certificates after dues payment has been received, members also be given the option of purchasing a wooden plaque and certificate printed on gold paper for display in their offices or elsewhere.

On motion of Doctors Blanchard–Curran, carried, the proposal was accepted, effective in 1960.

7. Forand Bill

Mr. Thayer reported that although hearings on the bill were concluded by the 86th Congress and it had been withdrawn by the author, it is almost certain to be re-introduced. Two actions by the Council were recommended through contacts by the AMA:

(a) Adoption of an official statement of opposition to the Forand bill and similar legislation.

(b) Authorization for arranging, in cooperation with the AMA staff, special public meetings in selected areas with concentrated programs on problems of the aging, at which high officials of the AMA would appear.

In discussion of a draft statement of the Society's position on the Forand bill presented by Mr. Thayer, the chairman asked Mr. Crownhart to report on the next item on the agenda.

8. Programs Relating to the Aging

The Executive Committee had discussed the apparent overlapping, if not duplicating activity resulting from wide public attention to problems of the aging, and the numerous state, regional and national conferences being scheduled on the subject. The Secretary read a statement drafted following this discussion the previous evening, proposing a coordinated effort in Wisconsin.

In discussion, there was some opinion that the statement proposed in (a) above and the latter statement might be combined. By agreement, action on these statements was deferred until the following day to give the Executive Committee an opportunity to consider preparation of a combined statement.

Returning to (b) above, it was pointed out that the AMA was interested in arranging several such conferences, and one in particular in the district of Representative Byrnes, a member of the House Ways and Means Committee.

On motion of Doctors Bell–Hill, carried, the staff was authorized to arrange for the special meetings as requested by the AMA.

Doctor Galasinski said he thought that one of these meetings should be held in Milwaukee in view of the fact that some official support had been given in favor of the Forand bill. He asked whether the county society should proceed to plan a meeting with the AMA, with assistance from the State Society. There was no disagreement with this proposal.

9. Potential Development in Care of the Migrant Worker

The Secretary reported as a matter of information that meetings with local doctors were taking place in an area where there is a concentration of migrant workers to study the possible future provision by the State Board of Health of some sort of screening service, possibly utilizing medical students, to eliminate those who do not require hospitalization or referral to physicians for care. This survey was prompted by a group interested in doing something for those migrants who do not seek medical care when needed because they have no money.

No action was taken, but Doctor Kilkenny indicated that the Division on Maternal and Child Welfare of the Commission on State Departments had concerned itself in the past with problems of medical care of migrant workers and would watch this situation.

10. Inquiry from AMA Concerning Medical Discipline

An inquiry from the AMA concerning the purposes of its Medical Disciplinary Committee had been circulated to the Council in advance of the meeting. It included several questions concerning disciplinary problems and procedures in this state.

In discussing the questions, the Secretary outlined a suggested reply which he proposed be specifically cleared with the Grievance Committee. The Council recessed during this discussion and the following action was taken when it reconvened at 1:00 p. m. on Saturday, July 25:

On motion of Doctors Conway–Curran, carried, the Council gave general approval to the outlined response, and asked that a copy of the reply be sent to the Councilors.

11. Implementation of Ethical Rulings

The Secretary asked for review by the Council of procedures in implementing the application of the Principles of Medical Ethics or other ethical pronouncements of the Council when violations become known. He said, for example, that when a statement such as that concerning association with ancillary personnel is issued and circulated, in some areas, at least, there seems to be no follow-up by the profession. The procedure now exists by former action that any specific situations are channeled from administration, probably through the Grievance Committee in most instances, and then to the Executive Committee of the Council; if the latter agreed that some action is indicated, it would recommend to the Council that the matter be directed to the local county medical society. Some councilors felt that if there is reluctance in the county society because of its size or some other reason, the matter should come back to the Grievance Committee or Council.

On motion of Doctors Fons–Ekblad, carried, this action was confirmed by the Council.

In discussion, Doctor Kilkenny asked that the Executive Committee consider a study of all ancillary fields, pointing out that with medicine broadening as it is, problems of ethical associations with other technicians must be faced in the near future.

12. Future Plans of the American Medical Association

The staff reported on the apparent aim of the AMA to provide more direct service to its members, as evidenced by its expanding field service activities, regional meetings, broader circulation of its publications, etc., and pointed out the potential impact on scientific and socio-economic programs of individual state societies in the future.

Following discussion, it was agreed that this matter be laid over to a future meeting when Doctor

Blasingame or one of his staff members can meet with the Council to discuss some of the problems encountered geographically by the AMA, and its future plans.

13. AMA Delegates' Report

The suggestion had been advanced that except for some special report when indicated, the detailed reporting of the AMA delegates from Wisconsin to the Society members be discontinued, with consequent savings, in view of the thorough reporting to members from the AMA itself through the newsletter, the Journal, and other communications.

This was also laid over with the above item. However, Doctor Kilkenny asked that the record show his recommendation "that the Executive Committee, in meeting with the national delegates, consider the possibility of a newsletter to the membership from time to time, apprising them to our local interest in the national problems."

14. Legislative Report and Action

Mr. Murphy gave a report of action by the 1959 Legislature on several of the major bills among the 175 having some degree of public health or personal interest to physicians, including a description of the legislative process and some of the outside influences which are brought to bear upon legislators.

As for Bill 129, A., which had passed both houses during the week, Mr. Crownhart stated his understanding that at the conclusion of the special Council meeting on July 12 it had been informally agreed that if the bill should pass, as amended by the Council and the Wisconsin Hospital Association, prompt effort should be undertaken by the new Commission on Hospital Relations and Medical Education to establish working liaison with the Hospital Association and begin to supplement gaps in the bill by agreements now, rather than waiting until it becomes effective.

Doctor Hildebrand added that it seemed better to place this responsibility under the new Commission, previous action of the Council being to assign negotiations on the legislation itself to the Committee on Public Policy.

On motion of Doctors Egan–Ekblad, carried, the chair was authorized to appoint a Council member to serve as liaison with the Commission on Hospital Relations and Medical Education on this subject.

On motion of Doctor James, variously seconded and carried, the Committee on Public Policy and legislative counsel were commended for a job well done during the 1959 legislative session.

15. Budgetary Report

The Secretary reminded the Council of action taken in April to suspend the 1959 budget, when it was foreseen that the amount normally allocated for various activities would be inadequate, which meant also the suspension of some Society activities. He reported his estimate of the total which would be reached for these unusual activities necessitating special meetings, bulletins, and so forth. He said that a final report would be made to the Finance Committee, together with a recommendation of some adjustment for legislative counsel in the current year.

He proposed also that the Committee on Public Policy be asked to analyze early in 1960 the extent and manner of the Society's support for the legislative programs of certain other groups.

On motion of Doctors Kilkenny-Blanchard, carried, the Secretary's report was received and placed on file pending recommendations of the Finance Committee.

16. Wisconsin Surgical Society Correspondence Concerning House of Delegates Meeting Schedule

The Secretary of the Wisconsin Surgical Society had written President Hildebrand requesting "that the Council of the State Medical Society consider the advisability of rearranging the meetings of the House of Delegates so that they will be held at an available time for the majority of the members of the State Medical Society attending the annual meeting. It is suggested that these could be held during the early afternoon of the regular meeting time and that there be no other conflicting meetings with these sessions."

This communication had been directed to the attention of the Council on Scientific Work, and the reply of its chairman, Doctor Huth, was presented to the Council. The reply discussed various aspects of the proposal and concluded in substance, that "the Council on Scientific Work feels that until such time as the House of Delegates is scheduled at a time other than the scientific programs of the Annual Meeting, the present schedule provides the least conflict of functions, and permits those interested parties to attend both the sessions of the House and the scientific teaching programs."

On motion of Doctors Conway-Blanchard, carried, this position was accepted by the Council.

17. Nomination to Advisory Hospital Council, State Board of Health

Three nominees were requested by the State Board of Health from which one will be selected to represent medicine on this Council for a three-year term.

On motion of Doctors Kilkenny-Ekblad, carried, the slate of nominees recommended by the Executive Committee was approved by the Council.

18. Nomination to Advisory Committee on Nursing Homes, State Board of Health

This committee also calls for medical representation, and the Society's nominee for a three-year term was requested by the State Board of Health.

On motion of Doctors Bell-Blanchard, carried, the recommendation of the Executive Committee was approved.

19. Council Award and Presidential Citation

The Secretary reminded the Council that if these awards are to be granted in 1960, the mechanisms of approval and preparation take time, and suggested that they be thinking of possible nominees.

20. Medallion for Presentation to Physicians Honored by Their Communities, or Similar Events

The Executive Committee recommended that a medallion be designed for presentation on such occasions.

On motion of Doctors Conway-Kief, carried, the Council approved the development of such a program.

21. Resolution of Commission on Medical Care Plans

The following resolution, adopted by the Commission on June 27, 1959, was forwarded to the Council:

"Be it resolved, that in recognition of the importance of having the general membership of the State Medical Society fully informed on basic matters, the Council be requested to have its chairman write the president and secretary of each component society to urge that the Councilor and Commissioner from each district be invited to make a report of major activities and policy decisions of Wisconsin Physicians Service to each component society in their area at least once a year, each letter to identify, by way of reminder, the appropriate Councilor and Commissioner."

On motion of Doctors Hill-Ekblad, carried, the chairman was so instructed.

22. Councilor District Reports

There was discussion of the bylaw requirement that each Councilor make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the Council. Due to the press of other business, little time has been devoted to these reports the past several years. A motion to recommend repeal of this section of the bylaw was lost, and it was generally agreed the annual reports should be reinstituted.

23. Special Liaison Committee

Doctor Hildebrand reported that he had received a verbal proposal for creation of a special liaison committee with the State Medical Society, to meet on a moreorless permanent basis to discuss mutual problems which are bound to arise as a result of apparent changing attitudes in the AMA towards a group now generally holding an unlimited license.

Following discussion, it was concluded that no action should be taken by the Council until such time as a formal request is received.

24. July 1960 Meeting

The staff was asked to look into the possibility of securing accommodations at another location, which probably would not be available before 1961, and to hold the reservation at King's Gateway for 1960.

As for this year's meeting expenses, on motion of Doctors Blanchard-Lokvam, carried, the Secretary was authorized to utilize the same method as last year whereby a per diem credit is applied against individual Councilors' charges for each day they are committed to meeting attendance.

25. Report of Executive Committee

(a) Recommended action on statements concerning problems of the aging.

The Executive Committee recommended that the two statements presented the previous day not be combined, since the proposal of a coordinated program for care of the aging would then appear to be prompted solely by Forand-type legislation and not by other considerations involved.

On motion of Doctors Egan-Kilkenny, carried, the Council agreed that the two subjects require separate statements.

(b) Statement of the Society's position on Forand-type legislation.

The committee recommended adoption of the statement presented, as follows:

"Hearings have been concluded on H. R. 4700 for the current session of the 86th Congress. It is evident that neither the nation's welfare nor the health of the aged adequately will be served by legislation to provide surgical-medical-hospital and nursing home care through the mechanism of the Social Security Act.

"Under Forand-type legislation the individual would suffer both as citizen and patient. He would be discouraged from providence and family responsibility; he would in effect be compelled to accept government benefits regardless of need or desire; his free choice of physician would be markedly reduced, and the personal relationship with his physician severely handicapped.

"The patient would find his course of treatment controlled as much by bureaucratic regulation as by his condition, the utilization of hospital facilities beyond either his control or that of the hospital management, and the standards of medical care affected more by political whim than by professional judgment.

"The nation's economy would reel under the initial cost and the completely unpredictable financial burden of the future. Acceptance of a compulsory program for so large a segment of the population is an invitation to expansion for all. Voluntary efforts at health insurance, health services and facilities would be completely discouraged.

"The Society must oppose such legislation. At the same time it must encourage still further the Society-financed studies of insurance needs of the aging, expansion of plans for those over 65, and joint efforts with voluntary and local governmental agencies for improved health care of the aged. Certainly medicine's initiative and imagination can be tapped again and again for new and revised methods of assuring adequate health care for all the aged who need it."

On motion of Doctors Hill-Ekblad, carried, the above statement was adopted by the Council.

(c) Statement on care of the aging

The Executive Committee recommended its adoption as presented:

"The subject of adequate safeguards in the care and protection of our senior citizens is being brought into sharp focus in the next several years. State and regional conferences will precede a Presidential Conference in 1961.

"The facets of this matter are many, but those which hold the most public attention are adequate facilities for domiciliary care and the health needs of these deserving people.

"A great deal has already been accomplished, particularly so in Wisconsin.

"Laws relating to the establishment, conduct and regulation of nursing homes in Wisconsin are administered by the State Board of Health.

"Some insurance organizations are offering good programs of prepaid health care.

"Civic leaders in many areas of Wisconsin are directing local efforts to ascertain and alleviate problems encountered in local areas.

"The Council of the State Medical Society believes, however, that much more can be accomplished and long-range planning will be more realistic if there is developed a centralized source of information with adequate facilities for research and reporting.

"Such a facility should be state-wide, have official standing, and be adequately financed. While this might be accomplished through existing voluntary organizations, its optimum efficiency will ultimately demand the official interest of the state.

"Senior citizens deserve all the privileges they enjoyed during their more productive economic years. Among these are freedom of choice of their medical care and hospital facilities; the ability to purchase and retain insurance against unanticipated costs of health care; retention of the right of privacy; and above all, preservation of their dignity and their constitutional guarantees.

"It is upon these and other considerations that the Council:

"(1) Requests each county medical society to establish a committee on care of the aging, such committees to act in cooperative effort with the State Medical Society's committee now in existence and functioning.

"(2) Asks that such county society committees be organized by early fall of this year.

"(3) Suggests that each committee inform itself, its county society and the State Society on facilities within the area of the county or counties for which the society is organized, and include within its survey such matters as costs, public health safeguards, free choice of medical and hospital facilities, and needed coordination of local efforts.

"(4) Invites the State Board of Health to conduct an early study of its structure to the point that it determine the feasibility of creating a division especially assigned to coordination of studies, research and recommendations as to present and potential needs of Wisconsin's senior citizens.

"(5) Asks those organizations providing senior citizens with prepaid plans of health care to develop a method for pooling their experience, that for the good of all, these programs be extended and improved as knowledge is gained in this area of economic effort.

"Such pooled information will be of excellent assistance to such studies as that of the School of Commerce, University of Wisconsin, now being conducted with financing from Wisconsin Physicians Service of the State Medical Society.

"(6) Invites each member of the State Medical Society, and others with particular responsibilities and concern for the senior citizen, including doctors of dentistry, nurses, pharmacists, hospital administrators and their boards of trustees, and others to join in this total coordinated program . . .

"All in recognition that youth, maturity and seniority in citizenship are each component elements of a strong democracy, and Wisconsin, always a state to pioneer, will again be one to lead the way in constructive and realistic programs of essential public welfare."

On motion of Doctors Kilkenny-Galasinski, carried, this statement was adopted by the Council.

(d) On motion of Doctors Kilkenny-Galasinski, carried, the final recommendation was accepted that implementation of the latter statement be by the Division on Aging of the Commission on State Departments in liaison with the Executive Committee of the Council.

26. New Business

On Doctor Egan's request for indoctrination of new councilors, Doctor Fox asked if it would be agreeable, since discussion of the subject would take time, that the staff prepare material for presentation at the next meeting.

On motion of Doctors Lokvam-Kilkenny, carried, the Council asked that this be an item on the next agenda.

On the matter of televison programs, it was suggested that at the next meeting one of the films might be presented and by that time further information obtained on their sponsorship, distribution, etc.

On motion of Doctors Frank-Kilkenny, carried, the Council asked that more information be presented at the next meeting.

As for the report on the financial condition of Wisconsin Physicians Service, the Council was agreeable to holding this for a subsequent meeting when the audit through June 30, 1959, is completed.

27. Adjournment

On motion of Doctors Bell-Kilkenny, carried, the Council adjourned at 4:40 p.m. on Saturday, July 25, 1959.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M. D.
Chairman of the Council

Minutes of Special Council Meeting Madison, October 11, 1959

1. Call to Order and Roll Call

The Council was called to order by Chairman Fox at 10:00 a.m. on Sunday, October 11, 1959, at the State Medical Society in Madison.

Councilors present were Doctors Lokvam, Hill, Houghton, Dessloch, Blanchard, Kief, Fox, Bell, Mason, Frank, Ekblad, Conway, Egan, Fons, Galasinski, Kilkenny, Curran, and Past President Kasten; officers present: President Hildebrand, President-elect Sorenson, Vice Speaker McGreane; members of the Commission on Medical Care Plans: Doctors Carlson, Casper, Davis, Goldstein, Hirsch, Mason, Moore, Nordby, Reznichek, Simenstad, Sprague, Supernaw, and Wolf. Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Toser, Doran, Doege, Koenig; Murphy, legal counsel; White, certified public accountant; Tiffany, consulting actuary; Mrs. Anderson and Miss Pyre.

2. Wisconsin Physicians Service Operations

Doctor Fox turned the meeting over to Doctor Dessloch, chairman of the Commission on Medical Care Plans, who asked Mr. Toser, insurance director, to present the material prepared at the request of the Commission for the entire membership of the Society, and contained in the pamphlet entitled, "Facts and Figures Relating to the Operations of Wisconsin Physicians Service," circulated to all members of the Society.

Mr. Tiffany was then called upon for comment, and he concluded his remarks with this summary: "I simply say that you should consider both the financial balance sheet (of June 30, 1959, as incorporated in the formal presentation) and the rate structure; that the responsibility for the rate structure is exclusively mine, and that WPS is, in fact, meeting this problem in a progressive, energetic way."

A period of discusison followed, during which Doctor Bell and others posed the question, "What can the Council do to benefit the competitive position of WPS?"

Eventually, Secretary Crownhart made the following statement, quoted verbatim:

"I was asked a question at one point here and haven't had opportunity to answer it as your general manager. Specifically, what does the staff want? What does it need to stop an intolerable situation?

"I think it needs one thing very immediately from the Council. In the past two years we have been spinning our wheels to beat hell, getting special reports and running around with a little squirt gun putting out fires. If we can be permitted to engage in business administration without special research and charts for awhile, it will be extremely helpful to the staff; and I think meetings, in terms of time and effort and energy and worry, have almost exhausted some of us. Hours of preparation in which we've tried to give you facts.

"Secondly, these two reports bear a statement which for the first time since I've been secretary in any official document has been added: Copyright, 1959, by the State Medical Society of Wisconsin. That isn't because of the Council and officers; that is because of our knowledge of the fact that were these reports not copyrighted, extracts would be taken out by competitive individuals, maybe some of whom might even be insurance companies, and I can think of a couple of insurance companies that I don't care very much about.

"The Council and the officers, as well as the Commissioners, can do a great deal if they will open up their county meetings, including Milwaukee County, to a presentation of WPS. It's been many years since there's been assembled a Milwaukee County meeting in which the physicians of that county have the reports that are readily available to other county medical societies to which we receive frequent invitation. Next Wednesday I'll be in Ashland and that's a darn sight farther than Milwaukee. I can always get over to Milwaukee readily, or I can see, and I think I still have a sufficient sense of diplomacy, I can see that highly competent individuals other than Mr. Crownhart could attend a Milwaukee County meeting.

"I would like to feel that the Council and officers would recognize the emergency character of some of these competitive problems. A company with which I'm associated, and incidentally, it does not make anything of a medicinal line or a hospital line, it makes industrial mufflers, can assemble its board virtually on a day's notice to handle competitive problems or managerial problems. This is one of the remarkable Council meetings in my memory because every one is here but one, and a majority of the Commission is here.

"But to meet rapidly, to handle competitive problems ethically, firmly and strongly, requires very rapid action and thus the Executive Committee of the Commission has scheduled regular monthly meetings and is so composed that special meetings can be handled. I'd like to feel that the judgment of the Commission, of the staff, and the Commission's Executive Committee will be one which will be supported by the Council and officers in the sense that you are saying to all of us: WPS is a program of the SMS authorized by the House of Delegates, and you don't let it go to pot.

"If that is the consensus of the group here, then I would feel that beyond any question, and as a matter of routine, we can take evidence of improper conduct to insurance authorities. Whether the insurance au-

thorities act upon it, that's something else; but presumably, if our evidence is correct and if it supports our contention, we could expect cooperation from public officials. And when I say insurance authorities, I include the courts because an administrative agency can often advise and direct, but it doesn't have the power to enforce in some respects. Now, if an individual takes a letter from an unnamed physician and reads only portions of it, and that particular salesman, be he of the service type or of the indemnity type, causes us a loss of the risk, I think we should be able to go out and stop that approach even to the point of getting an injunction, not prosecute him criminally, of course, but enjoining him through legal process from doing an improper act.

"We report to you in the audit that there's every reason to believe that Blue Cross is indebted to us. Blue Cross refused to acknowledge that indebtedness. There, then, is presented a legal problem. I believe the Commission should very properly submit that claim of about $25,000 to other than our own regular legal counsel because our own counsel, our duly appointed counsel, participated in the negotiations and therefore would have to be witnesses in the case, and it would not be an easy matter to be a witness and at the same time a lawyer interrogating yourself.

"And I believe that legal counsel who have particular experience in unfair competitive practices should be secured by the Commission. You all know that Bob Murphy was my law partner at one time. I have high respect for his abilities, for his judgment, for his character, as well as his ethics. But just as any physician might seek consultation on a case that he has, or indeed seek treatment from physicians in another state, as general manager I feel that the particular situation with which we are confronted requires and should have consultation by a group of attorneys who specialize in the field. So there is another recommendation.

"I would like to feel, and not necessarily that you have to vote on all these things, but that it is inherent in the management of the Society affairs that we take the protective steps necessary to keep us in operation.

"And finally, I would like to have the Commission consider and recommend to you at some subsequent date a petition to Surgical Care asking it possibly to sever in total its relationship with Blue Cross. Now let me state this. Surgical Care has approval of the State Medical Society, unqualified as to its character but limited as to its territory. If our contention is proved correct, and at this point it is but a contention, that we are dealing with a highly emotional group of people in one particular type of organization, that they have become so emotional and imbalanced that they have become arrogant, unethical in the business sense, domineering, and if their objective seems to be destruction rather than promotion of voluntary insurance, they seek to make it virtually an exclusive franchise under their control, and that in all this mechanism they have used Surgical Care and used the blanket of the Surgical Care emblem to give an air of propriety about their conduct—I am sure that Milwaukee County would feel equally as strongly were the situation reversed and would petition the SMS not to give support to enemies of medicine. And so as the evidence accumulates and the records develop, it might well be that the Commission should consider and you should ultimately act on a proposal seeking to have Surgical Care terminate its agency relationship with this particular group.

"I would like to feel also that the Council, and I think Doctor Egan with his background can appreciate these remarks maybe more than many others, that the Council will seek some method to terminate duplicating studies and duplicating efforts. For example, there's a special committee. I don't oppose special committees, but this one is doing exactly, in a study sense, everything the Council's done over a period of years. It's next meeting will be October 25, and at that time I'm expected to engage in a day-long presentation of the budget of the State Medical Society. If I could just go to a meeting and sit down and say, now here's the budget, but the budget of the State Medical Society, exclusive of WPS, is $320,000 or $340,000 a year. It should, I hope it does, divide out about 50% for labor and 50% for facility—that's a rule of thumb for a voluntary association. Now that wouldn't be too much of a demand. That would just be another Sunday, but that isn't what happens. The budgets are all in the process of being duplicated so that every member of that committee may have a copy of it, and that means duplicating material that we thought was not needed after the budget was acted upon, probably 20 pages of material that took two sessions of the Finance Committee and about three or four hours of the Council in total.

"Now I am responding specifically to what does the staff want. We can't tell you what to do. We can only relate these things as problems to you. We are overwhelmed, overloaded, exhausted, but still patient in preparing report after report, slide after slide, and meeting after meeting, in mulling over a thing that's been decided or acted upon on some prior occasion. The rules of the Council are duly enacted by it on motion, seconded after discussion, and they then become the control. You can always reconsider. You have the right at any time to reconsider any past action. As a matter of fact, some of you will recall that for ten years I've been trying to get you to reconsider an action of the Council in which you told me I could accept liquor advertising in the *Wisconsin Medical Journal* but I couldn't solicit it. I always felt there was a mild amount of inconsistency in that particular action. We would like the opportunity, then, to get the wheels of WPS on solid ground and not spin around quite so much in various concentric circles which threaten to put some of us into orbit.

"Then, in summary, that we have appropriate legal advice of a specialized character; the county

medical society meetings be actively encouraged; that it be inherent in the operation of our program that where there is cause to be concerned over what we believe to be unethical or improper, it is inherent that we have the right to take that to authorities who can rule upon it.

"Those are general and any one of you might have reason to say, give examples. But it's just like much of your surgery—I don't want to confine that to the surgeons, by any means, that would include the internists as well, the pediatrician. There are no exact laws of science in medicine; in a general way perhaps there are. There are no exact laws in law; but we would like to think that within the total of 45 doctors or 48 doctors who constitute the total management of these many facets of our activities, that their inherent authority and their fine dignity be preserved against the challenge of those who would reduce medicine, and ultimately hospitals, to the administrative dictates of a bureaucratic government. Believe me, that challenge is very real. I think, Doctor Dessloch, if our staff can leave this meeting with that impression of the cooperation of the Commissioners, officers, councilors, the like, that then we know the course ahead is clear. We have never let you down. There's never been a statement before any of these groups that we haven't been in a position to prove, and we've even proved statements of two years ago that we were being substantially overcharged by our then agent. That is no longer an estimate. That is no longer my opinion. That has been proved. And needless to say, I'm happy about it. Because if it had gone the other way, I wouldn't be talking quite so calmly; but we have proved it as we've proved every other claim we've ever made here. I don't say that to boast. I say that to tell you that the staff has its ethical concept of its responsibility. We don't thing that we should move a committee or an individual by emotional charges that lack support. We may get into an emotional delivery, I don't know who doesn't at times. But when we go before any of our committees, it's been mulled over and mulled over, no matter what it is, within the staff first, so that we can go into a committee and say here's what we think and why we think it, and we've thought it out to the best of our ability; now we lay it before you.

"Gentlemen of the Council and of the Commission, this matter of what does the staff want wasn't a new question. It's been a question that's been going through the staff's mind month after month and night after night. What I have given you here is, I think, the consensus of what the staff wants, as I've talked to them in repeated conferences. Thank you very much."

Following recess, when Doctor Fox again took the chair, Doctors Bell–Kilkenny moved that the material presented in the brochure be presented personally to the membership of the State Medical Society, either through county or councilor district meetings, by the staff, including remarks by Messrs. Toser and Tiffany. Motion carried.

Doctors Curran–Conway moved that the Council approve the requests made by the staff, as a matter of record; motion to include remarks made by the Secretary prior to recess in answer to what the staff wants from the doctors.

On motion of Doctors Dessloch–Galasinski, carried, the above motion was amended to strike the matter of a petition to Surgical Care for separate action.

The motion of Doctors Curran–Conway was approved as amended.

On motion of Doctors Dessloch–Bell, carried, if the Commission or the Council feels it necessary, the problem of Surgical Care and its affiliation with Blue Cross be placed on a Council agenda at an appropriate time with sufficient notice for discussion.

On motion of Doctors Conway–Egan, carried, the Council requested a monthly narrative report on the operations of Wisconsin Physicians Service "until this is levelled off."

Doctor Lokvam raised question as to the proper allocation of the extra expense involved in this special Council meeting to report on WPS finances and preparing monthly reports. Chairman Fox proposed that at the next meeting there be a report on costs for Council decision as to where they should be borne.

3. Committee on Federal Legislation

Doctor Fox reported that although this was a special Council meeting, the Executive Committee, which had met the previous day, wished to report what it considered an emergency recommendation for Council action; that the president, the president-elect, and the chairman of the Council be authorized to appoint a committee on federal legislation.

Doctor Hildebrand reported on a recent AMA Legislative Conference in which state societies were asked to activate strong committees to combat For-and-type legislation.

On motion of Doctor Egan, variously seconded, the Council authorized appointment of such a committee.

4. Commission on Hospital Relations and Medical Education

On motion of Doctors Frank–Egan, carried, Doctor Quisling, chairman of the Committee on Public Policy, was asked to serve in liaison capacity with the Commission on Hospital Relations and Medical Education in its assignment of codifying Bill 129, A., enacted as Chapter 484, Laws of 1959.

5. Adjournment

The Council adjourned at 2:55 p.m.

C. H. Crownhart,
Secretary

Approved:
James C. Fox, M.D.
Chairman of the Council

Wisconsin Individual Income Taxes

INTRODUCTION

The material which follows is designed for the assistance of physicians, their office staffs, and tax advisors. It is an effort to present in summary form the principal provisions of the Wisconsin Income Tax Statutes enacted prior to December 1, 1959, which are of general application or which have particular interest for physicians.

As of the above date two bills were pending before the recessed session of the Wisconsin Legislature relating to individual income taxes. One would substantially increase rates and also increase exemptions. The other would establish a withholding system for employed persons and a prepayment system for the self-employed generally similar to that found in the federal income tax system. Neither bill as drafted would apply to 1959 income. There is no way of ascertaining whether either will become law, and if so, in what form. For these reasons no detailed information is offered on either bill in this article which is concerned primarily with the reporting of 1959 income.

As a matter of general information to physicians the 1959 legislature left the normal tax on individual income graduated in rates varying from one percent on the first $1,000 of net taxable income to 8½% on the excess over $14,000. In addition, a surtax of 25% of the normal tax was established for 1959 income. This must be paid *in addition to* the normal tax.

INCOME TAX RETURNS

Liability to Make Tax Return. Every resident must file a return, who:

(1) has gross income of $600 or more.
(2) is a married person receiving any net income during the year when the combined net income of such person and his or her spouse is $1,400 or more.
(3) is requested to file by the State Department of Taxation.

Every person having a legal residence in Wisconsin, and every other person maintaining a permanent place of abode here, or spending in the aggregate more than seven months of the income year within the state, shall be deemed to be residing in Wisconsin for purposes of determining liability for income taxes and surtaxes. When a person changes his permanent residence to or from Wisconsin during the year, liability to taxation for income which follows residence shall be determined on the basis of the income received during the part of the year such person was a Wisconsin resident. Personal exemptions are prorated on the basis of time of residence within and without the state.

Joint Returns. A 1959 amendment permits the filing of a joint return by husband and wife. This has not been permitted in earlier years. Instead of having several return forms for individuals, Wisconsin now has only Form 1. This is to be used for a combined husband-wife return, by husband or wife individually, by a head of family, or by a single person. This form is also to be used irrespective of the size of income.

Tax Tables; Optional Deductions. These subjects should be determined in the individual case after a careful reading of the new Form 1, pages 4, 5 and 6; and Section II p. 2 of Instruction Sheet—1959, which accompanies the form. These pages describe what tax tables apply, what options are open as to reporting expenses or taking standard deductions and related questions.

Return Due Dates. Wisconsin individual income tax returns must be filed with the Assessor of Incomes of the district in which the physician resides, on or before April 15, 1960, for those on a calendar year basis. For those on a fiscal year other than a calendar year, the return is due by the 15th day of the fourth month following the close of such year.

Payment of Tax. If the tax is $20 or less, the total amount must be paid by the date on which the return is due. A tax of more than $20 may be paid in two installments, except that the first installment must be at least one-third of the total tax, (normal plus surtax) or $20, whichever is greater. In the case of calendar year taxpayers, the first installment is due by April 15, and the balance by August 1. Two percent must be added to the amount of the installment deferred.

Physicians on a fiscal year basis must pay by dates corresponding to those of calendar year taxpayers. Thus a physician whose fiscal year closed June 30 would have to pay at least one-third of his tax by October 15 and the deferred installment by the following February 1.

MINORS

A guardian, irrespective of whether a parent or another person, must file a return for a minor whose gross income is $600 or more. The parent or head of family need not report such income on his personal return.

The Wisconsin statute treats a minor as a separate taxpayer, subject to the legal requirements as to filing of returns and payment of taxes.

The personal exemption allowable to the minor or guardian shall be the same as that allowable to any other person.

Where the gross income of the minor for the calendar year is $600 or more, the parent is not allowed to consider the child a dependent.

Liability for the tax on income of a minor child is placed on the parent if not paid by the child.

GROSS INCOME

Following is a *partial* list of what must be reported as gross income on a Wisconsin return: All fees, salaries or other personal compensation; the distributive shares of partnership net income to the extent that such net is attributed to business transacted and property located in Wisconsin; all rents from Wisconsin real estate; annuity, pension, retirement or similar payments, (except for exempt governmental pensions described under "Excludable or Exempt Income") as to amounts received in excess of the physicians' contribution or cost; cash dividends, except from life insurance; commissions and royalties; and capital gains, to the extent taxable as described under the heading "Capital Gains and Losses" (see below); sick pay received from an employer; interest on state and local government obligations, and from private investments; and unemployment compensation received.

EXCLUDABLE OR EXEMPT INCOME

The following kinds of income need *not* be reported on the individual return because they are *not* taxable:

Alimony received; $1,000 of compensation received for services as an active or reserve member of the U. S. Armed Forces; veterans disability payments (not including benefits provided under retirement plan); Social Security and Railroad Retirement Benefits; Milwaukee City and County retirement; Wisconsin teachers retirement; Wisconsin State retirement (retired before 1/1/48); damages for personal injury; interest from U. S. securities (postal savings interest is taxable); rents from and profits from the sale of real estate outside Wisconsin; all inheritances, devises, bequests, and gifts received during the year; all insurance received by any person or persons in payment of a death claim by any insurance company, fraternal benefit society, or other insurer, *including* insurance paid to an individual or partnership on the lives of partners or employees.

CAPITAL GAINS AND LOSSES

Capital gains on business real estate are taxable on the Wisconsin return only when the property is located in this state. Similarly, the gain on sale of tangible personal property is taxable only when such property had its usual location, or situs, in Wisconsin. Consistent with the above, losses on business real estate or tangible personal property may be taken only on Wisconsin property.

The gain on sale or other disposition of intangible personal property, such as stocks or bonds, must be reported by Wisconsin residents irrespective of where such property is located.

Full gains or full losses are recognized, irrespective of the length of time the asset was held. However, gains on sales, other than nonrecognized gains on sales of residences, may be reported on the installment basis provided 30% or less of the sales price is received during the first twelve months following the date of sale.

GAIN OR LOSS ON SALE OF RESIDENCE

Wisconsin has adopted substantially the federal rule on the sale or exchange of the taxpayer's principal residence except that both the old and new residences must be located in the state in order to claim the advantages of the statute. This matter is carefully treated on pages 3 and 4 of the Instruction Sheet—1959, which will accompany new Form 1.

ANNUITY RULE

As distinguished from the federal rule governing annuity income, the Wisconsin rule provides that annuity payments under a pension, retirement, endowment or annuity contract are income to the extent of any payment *after* the income tax cost has been recovered. "*Income Tax Cost*" means the aggregate premiums or other consideration contributed by the taxpayer. When the contract provides for the separation of the periodic payment into principal and interest, the interest so received is taxable in the year received.

PERSONAL EXEMPTIONS; DEPENDENTS

Personal Exemptions. After the tax has been computed, personal exemptions are deducted in arriving at the net tax payable. A $7 exemption is allowed for the taxpayer, an additional $7 for the spouse, and an additional $7 for each dependent whose gross income is less than $600.

An additional $7 is allowed a "head of a family," who is defined to mean an unmarried taxpayer who maintained a household and supported therein a dependent as well as himself. For example, a widower maintaining a household in which he supported his three-year-old son would be entitled to total exemptions of $21.

Dependents. The age of the dependent or his ability to support himself is not material. A dependent means one of the following persons, over half of whose support for the calendar year was received from the taxpayer, and whose gross income was less than $600:

1. A son or daughter of the taxpayer, or a descendant of either.
2. A stepson or stepdaughter of the taxpayer.
3. A brother, sister, stepbrother, or stepsister of the taxpayer.

4. The father or mother of the taxpayer, or an ancestor of either.

5. A stepfather or stepmother of the taxpayer.

6. A son or daughter of a brother or sister of the taxpayer.

7. A brother or sister of the father or mother of the taxpayer.

"Brother" and "sister" include a brother or sister by the half-blood. A legally adopted child is considered a child by blood.

Any dependent other than the child of a taxpayer must be a resident of or domiciled in Wisconsin, or the taxpayer will be disqualified from claiming such dependency.

A taxpayer who was married during the year and claims an exemption for his wife is entitled to a full exemption for her during that year, if at the close of his taxable year he was still married to such spouse, or, if she died during the taxable year, he was married to her on the date of her death.

The fact that a dependent was not in existence throughout the year is immaterial. Thus, if a child of the taxpayer is born or dies during the taxable year, a full exemption is allowable for such child.

The deductions for personal exemptions must be prorated on the basis of the time of residence within and without the state in the case of those taxpayers or their dependents who move into or out of the state within the taxable year.

DEDUCTIONS

A. General

The Wisconsin Statutes gives a taxpayer with an adjusted gross income of $5,000 or more the choice of (1) taking an optional standard deduction, or (2) itemizing his allowable deductions on page 2 of new Form 1. Such deductions are in addition to "ordinary and necessary expenses" paid in carrying on the profession or business from which the income is derived. The latter are deductible in Schedule H, page 4 of new Form 1. In most cases physicians can reduce their income tax liability by itemizing their deductions on page 2 of Form 1, rather than electing the optional standard deduction of $450.

Sections B and C which follow this section treat, from the standpoint of the physician, items which fall into *both* categories because both have the effect of reducing their tax liability on reportable income. The fact that "ordinary and necessary expenses" are used to establish their adjusted gross income, and that so called "deductions" as enumerated on page 2 of Form 1 are used to reduce their adjusted gross income once that figure has been ascertained, is a technical consideration of little interest to him.

B. Index to Deductions

This index is designed to assist the physician in ascertaining what deductions are allowable. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in some detail what deductions are allowable.

Automobiles, 1.
- Depreciation.
- Driver, 1.
- Insurance, 1, 3.
- Maintenance.
- Professional use.
- Repairs.

Bad debts, 2.
Bandages, 8.
Conventions, 7.
Contributions and gifts, 15 (f).
Depreciation.
- Automobiles—percentage annually of cost price, 1.
- Instruments, 8.
  - 10 per cent annually of cost price of surgical instruments and general equipment; 10 per cent on x-ray equipment.
- Medical library, 5.
- 10 per cent annually of cost price.
- Office equipment, 9.
  - 10 per cent annually of cost price.
- Professional equipment, 8, 15(a).

Dues, 11.
Entertainment expenses, 16.
Fire, loss by, 6.
Instruments, 8.
Insurance premiums, 3.
- Automobile, 1.
- Hospital and surgical, 15(g).
- Malpractice, 3.
- Professional equipment, 3.

Interest paid, 4.
Laboratory materials, 8, 15(a).
Legal expenses, 15(b), 15(d).
Library, 5.
Licenses, 12.
Losses, by fire, flood, theft, suit, etc., 6, 15(d).
Medical expenses, 15(g).
Medical meetings, 7.
Medical Society group health and accident annual premium, deduct $16.80. See 15(g).
Medical Supplies, 8.
Miscellaneous, 15.
Office expenses, 9.
- Heat, light, supplies, telephone, water, short-lived office equipment, annual depreciation on furnishings and fixtures.

Office rental, 10.
Professional conventions, 7.
Professional dues, 11.
- American Medical Association.
- County Society.
- State Society.
- Special societies as:
  - American College of Surgeons.
  - American College of Radiology.
- Any other paid in interest of profession.

Professional subscriptions, 5, 11.
Salaries, 14.
Sales of eye glasses, 15(c).
Scientific meetings, 13.
Subscriptions, 5.
Taxes and licenses, 12.
- Automobile licenses.
- Federal income—3 per cent maximum.
- Import duties, etc.
- Personal property taxes.
- Professional license fees.
- Real property taxes on office owned and used by taxpayer in practice.
- Social Security taxes.
- Wisconsin income taxes and surtaxes paid.
- Wisconsin and Federal unemployment taxes.

Theft, loss by, 6.
Traveling expenses, 7, 13.
- Both professional calls and scientific meetings.

Wages and salaries, 14.
- Clerk, 14.
- Driver, 1.
- Laboratory assistant and technicians, 14, 15(a).
- Maid, 14.
- Nurse, 14.
- Stenographer, 14.
- Any other employee rendering service in connection with taxpayer's practice or in the care and treatment of patients, 14.

C. Explanation of Deductions

1. Automobiles. For Wisconsin income tax purposes, the cost price for an automobile, or other business property, acquired on a trade-in of a similar asset is the list price of the asset, regardless of whether it was an outright purchase or a trade-in deal. The Wisconsin rule is in this respect different from the federal rule.

The cost of operation and maintenance of an automobile used in making professional visits is deductible. These costs include gasoline, oil, tires, insurance, repairs, garage rental, driver's wages and depreciation. If the same car is used for both professional and personal purposes, only such part of the maintenance and depreciation as arises out of the use for professional purposes is deductible. Sums spent for taxi, bus, or railroad fare, *while on professional calls*, are deductible.

Depreciation is based upon the estimated useful life of the car. If that period be five years, 20 per cent depreciation based on cost price may be taken annually for five years, unless another permissible method of depreciation is used. What has been said with respect to automobiles applies to other motive equipment.

2. Bad Debts. If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not deduct from income any unpaid accounts because such items were never included in reported income.

If the books are kept upon an "accrual basis" (that is on the basis of expenses actually incurred and payable even though not yet paid, and income earned although not yet collected), it is permissible to charge off all accounts which have been definitely ascertained to be worthless, and have been charged off on the books or records during the fiscal year covered by the report.

3. Insurance Premiums. Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. This further includes premiums for various forms of insurance on the building owned and used in connection with the practice, or a fair proportion thereof where the building is also a home.

4. Interest Paid. Interest paid within the tax year on existing indebtedness may be deducted, provided that the debtor reports the amount so paid, the form of indebtedness, and the name and address of the creditor.

No interest is allowed as a deduction if paid on indebtedness created for the purchase, maintenance or improvement of income producing property, or for the conduct of a business, unless the income from such property or business would be taxable under the Wisconsin law.

Interest paid on state and federal income taxes is deductible, but interest paid on fines levied for violations of law is not allowable as a deduction.

Interest paid by an individual on indebtedness created for the purpose of acquiring a home is deductible. Likewise, interest paid by an individual on money borrowed to pay personal debts, such as hospital bills and other family obligations, is considered a proper deduction.

Interest paid by an individual on money borrowed for the purpose of securing an education is allowable even though other expenses of obtaining such education are not allowable.

5. Library. A fair rate of depreciation on the physician's library may be deducted covering wear and tear sustained through use. In determining the rate, however, obsolescence may not be considered since the Wisconsin income tax law does not recognize losses in value due to such causes. The fact that medical books become out of date during the course of ten years cannot be considered in determining the rate of library depreciation. An annual depreciation of 10 per cent of the cost of such library seems reasonable, however.

6. Losses by Fire, etc. Loss of and damage to a physician's equipment and other property, used by him in connection with carrying on his professional practice, by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent that it has not been made good by repair and cost of repair claimed as a deduction. Losses on business conducted or property located outside the state are not deductible.

Losses on automobiles, aircraft, summer homes, motor boats, furniture, etc., purchased and held for pleasure are deductible from gross income where sustained because of theft, fire, flood, or other casualty. In defining the word, "Casualty", Wisconsin has limited it to mean an act of suddenness uncontrolled by man. Thus a loss sustained on a pleasure car which ran off the road and hit a tree is not deductible. Losses on property used for both pleasure and practice are deductible only to the extent that such property was used in the practice, unless such losses were sustained through fire, flood, other casualty, or theft, in which cases the entire loss is allowable.

In the event a personal residence is sold at a loss, the loss is deductible on the Wisconsin return. If the residence was held jointly, each of the joint owners is entitled to deduct only one-half of the loss.

7. Medical Meetings. Ordinary and necessary expenses incurred in attending meetings of medical organizations, necessary to enable the physician to carry on his profession, are deductible. This includes travel expenses.

Costs of attending professional meetings must be strictly limited to the necessary cost and expense directly attendant upon such meetings. The type of professional meeting here contemplated is confined to such as are, as a general rule, ordinarily and generally attended by persons of the same professional standing as the taxpayer, as necessary to the maintenance and carrying on of their regular practice and profession.

8. Medical Supplies and Instruments. Medicines used in the physician's office to treat patients, bandages, laboratory materials, and all other medical supplies required for the operation of a physician's office may be deducted as necessary expenses, **as may small items of equipment, the life of which is less than one year.**

The average useful life of surgical instruments and equipment including x-ray equipment generally is estimated at ten years.

9. Office Expenses. General office expense is deductible. Among the principal items are heat, light, office supplies, telephone, rentals, water, small items having a useful life of a year or less, and depreciation on office furnishings and fixtures. Ten per cent of original cost is a reasonable *average* depreciation rate for office equipment, furnishings and fixtures. Specific items may be higher or lower than this rate. Thus, a typewriter which, it was estimated, would last only five years would warrant a 20 per cent annual rate; while metal filing cabinets, with an estimated useful life of twenty years, would justify only a 5 per cent annual rate.

Where the space used for the conduct of a professional practice, including waiting rooms, examination rooms and laboratory, is owned by the taxpayer physician, or by a partnership of physicians, a reasonable depreciation may be taken annually on such building, based on its cost and life expectancy. If only a portion of a building is used for professional purposes, depreciation may be taken only on such portion.

10. Office Rental. If a physician pays rent to another person for office space he is permitted to deduct the amount from his gross income. This includes office space in a rented home, provided office hours are maintained. Where a physician maintains his offices in the home which he occupies as a residence, he may, if the home is rented, deduct as rent that proportion of the total rent paid which the value of his office space bears to the rental of the entire premises; and if he owns the residence, he may deduct the proper share of expenses attributable to the space so occupied, including taxes, depreciation, insurance, water, light, heat, repairs and general upkeep.

11. Professional Dues and Subscriptions. Dues paid to professional associations to which a physician belongs in the interest of his profession are deductible. Subscriptions to medical journals or scientific publications are likewise deductible as expenses.

12. Taxes and Licenses. All taxes and licenses incident to the professional scope of the physician may be deducted. The following taxes would be deductible by any physician:

(a) Real property taxes paid on office or part of home owned by him and used by him in his practice.

(b) Personal property taxes paid on his furnishings and equipment.

(c) Wisconsin income taxes and surtaxes paid during 1959.

(d) Federal income taxes, provided that such deductions are limited to taxes paid in cash within the year covered by the income tax return on net income taxable under the Wisconsin law, the maximum deduction not to exceed 3 per cent of net income computed under the state law *before* deducting such federal taxes or any contributions.

(e) All license fees incident to his profession.

(f) Automobile licenses on automobiles used exclusively in the practice of his profession. See paragraph 1 supra.

(g) Import or tariff duties and business, license, privilege, excise, and stamp taxes, are deductible if incurred in connection with the carrying on of the taxpayer's practice and profession.

(h) All Social Security taxes paid by the physician in his capacity of employer and the amounts paid by him under the Wisconsin and Federal unemployment compensation acts. A salaried physician is required to include the amount of the Social Security tax paid by him in determining his gross salary. He is then permitted by the same rule to deduct the amount of the Social Security tax withheld from him and to include it as part of his federal income tax, subject to the 3 per cent maximum rule noted in subhead (d) above.

Taxes which are *not* deductible include: Real estate on residence property occupied by the owner; automobile license fee, gasoline, cigarette and amusement taxes, inheritance taxes, special assessment taxes; and taxes on vacant lots. However, physicians who use an automobile in the production of their income may include an appropriate percentage of the gas tax, and auto license fee as a part of the cost of operating the automobile.

13. Traveling Expenses (See paragraph 7).

14. Wages and Salaries (See 15 (e) below).

15. Miscellaneous.

(a) Laboratory Expenses—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of other corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when, under corresponding circumstances, they would be deductible if they were part of a physician's general office expense.

(b) Legal expenses incurred in the defense of a suit for malpractice are deductible as business expenses. Expenses incurred in the defense of a criminal action, however, are not deductible. Legal expenses incurred in connection

with the operation of a taxpayer's profession are proper deductions unless such business is conducted in violation of the law.

(c) Sales of Eye Glasses. Physicians who furnish eye glasses, etc., must enter as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for services separate and apart from charges for materials.

(d) Unclassified. Payments required to be made to others for damages growing out of the carrying on of the profession such as injury to property, interference with property rights, breach of contract, and libel are deductible. Damages of a personal character recovered against the physician, such as those for the surrender of the custody of a minor child, are not deductible because not related to the carrying on of the physician's profession.

Miscellaneous expenses which are incurred in producing taxable income and are allowable deductions include the following: fees paid to auditors, tax experts, and lawyers in connection with income tax matters, welfare work expense incurred in keeping up the morale in an office and organization.

(e) Informational Returns. All salaries, wages, fees, or other compensation for services actually rendered in connection with the physician's practice which total or exceed $600 in the case of any individual recipient, must be reported or such expense shall not be deductible. This information, which must disclose the name, the address and the amount paid each such person, can either be furnished as a part of the income tax return or reported on Form 9, which form will be furnished the physician by the income tax assessor on request. Similar information must be furnished either on the return or on Form 9, which should accompany the return, where deduction is sought on items of rent, royalty and interest expense.

(f) Contributions or gifts made to public, religious, educational, charitable, veteran's or similar organizations are deductible to an amount not in excess of 10 per cent of the taxpayer's net income after deducting the allowable portion of the federal tax.

(g) Medical expenses—payments in excess of $75 but not over $1,500 for hospital, nursing, medical, surgical, dental services and medical supplies incurred by the taxpayer on account of illness or of personal injury to himself or his dependents.

Premiums for policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Such premiums are deductible whether the benefits are payable directly to the source of service or as indemnity to the insured physician. Premiums for disability or time loss insurance and for accidental death and dismemberment are *not* deductible. Physicians enrolled in the Provident Life & Accident Insurance Company group disability and hospitalization plan, which has been carried through the State Medical Society since August 15, 1950, may deduct the hospital benefits portion of the annual premium, which is $16.80.

16. Entertainment Expenses. The statute allows deduction of reasonable expenses *for the entertainment of clients, patients, or customers.*

Whether the statute is broad enough to allow deductibility of entertainment expenses of specialists who entertain general practitioners referring clients to them has not been established. The Wisconsin Board of Tax Appeals has held under previous laws that such entertainment expenses were not deductible by a physician specialist, whose practice was made up almost entirely of referrals from general practitioners.

Likewise, whether the language of the statute is broad enough to allow deductibility of golf club dues and dues of similar organizations remains to be seen. Here, too, the Board of Tax Appeals had ruled, under other laws, that the social aspects of such "expenses" were too closely interwoven to allow deduction as ordinary and necessary business expenses.

IMPORTANCE OF ADEQUATE ACCOUNTING RECORDS

It is equally true under both the federal and the Wisconsin laws that a properly maintained set of double-entry accounts is probably the greatest single means of facilitating the preparation of a physician's income tax returns, and of enabling him to secure the maximum advantage from the expense and deduction statutes. Such a bookkeeping system is neither complicated nor unreasonably time consuming. It can be installed by any competent accountant at a reasonable cost, and can be maintained by any trained bookkeeper. A large number of tax complications would never arise if adequate accounting records were available to serve as the basis of tax returns, or as the authority for settling questions at an early stage.

It is suggested that a physician will find it economical, from the standpoint of time and money, to turn income tax matters over to his attorney or certified public accountant, so that he may concentrate in his own professional field.

What can the new tuberculosis patient expect?

Tuberculosis as a cause of death has dropped from first to 13th place in the past half century, but one new case is reported every five minutes in the United States.

This fact is revealed in a recent issue of *Patterns of Disease*, prepared by Parke, Davis & Company.

In the past 20 years alone the number of tuberculosis deaths has dropped about 80 per cent. The number of newly reported cases, however, has declined only about 20 per cent during this period.

This publication stresses the need for more intensive drives to detect the disease. For every known case, it reports, there is one unknown tuberculous person. Total number of known and unknown cases (both active and inactive TB) in the U. S. is estimated at 800,000.

"To eradicate tuberculosis," *Patterns* points out, "the disease must be detected and treated early, while lesions are small and readily amenable to therapy." Yet, for the past five years, only about 22 per cent of newly reported active and probably active cases have been in the early stage. In 1956, about 20 per cent of persons who died of tuberculosis had not been previously reported as having the disease.

Control of persons with active tuberculosis is important in preventing the spread of the disease, *Patterns* emphasizes. It cites one large-scale study of tuberculous children which revealed that about three quarters were infected by adults whose disease had not yet been diagnosed. About one sixth of the group contracted the disease from people known to have tuberculosis, some of whom had left sanatoria before treatment was completed.

Difficulty in Diagnosis

Are nontuberculous chest diseases sometimes confused with tuberculosis? About 1 out of every 6 patients admitted to hospitals with a diagnosis of tuberculosis actually has a nontuberculous chest disease, *Patterns* reveals.

It reports that diagnosis of histoplasmosis, a serious respiratory disease caused by a fungus, "is being made with increasing frequency in these cases."

In the five-year period beginning in 1952, histoplasmosis as a final diagnosis in nontuberculous chest cases originally diagnosed as tuberculosis more than doubled—jumping from about 7 per cent in 1952 to 15 per cent in 1956.

The publication also deals with misconceptions concerning the causes of reactivation of the disease. Although reactivation has been blamed on a variety of factors, such as heavy physical labor and pregnancy, *Patterns* says, today it is believed principally to depend on the extent of the disease.

"Experience has shown that pregnancy in itself is not responsible for relapse, nor is return to previous occupation involving moderate or even heavy work."

Geographically, the incidence of infection by tubercule bacilli, as determined by the tuberculin skin test, is less than 10 per cent in most of the country. However, incidence in the east central and southwestern states is considerably higher.

Tuberculosis rates are higher in cities, with death rates in cities of population over 500,000 almost double that of the United States exclusive of large cities.

The sex ratio of mortality from tuberculosis has reversed during the past century, it discloses. TB death rates, considerably higher among women in the 19th century, are presently much higher among men. In 1956 over 70 per cent of tuberculosis deaths occurred among men. Incidence, too, is much higher among men, an estimated 2 out of 3 patients now being men.

As far as age is concerned, although at present most reported cases of the disease are among persons in the productive age groups, tuberculosis is increasingly a disease of older persons.

Chemical Weapons

Thanks to modern medical advances, the outlook for the new tuberculosis patient is brighter than ever before, *Patterns* reports.

"Since 1947 revolutionary changes have been effected in the treatment of tuberculosis," it says. "The greatest single cause of these changes has been development of antimicrobial agents active against tubercule bacilli. Thus the past eleven years has seen the increasing use of chemotherapy—from its use on less than 10 per cent of tuberculosis patients in 1947 to more than 90 per cent in 1957.

These chemical advances have influenced surgical treatment of the disease, reducing the use of permanent collapse methods and allowing such methods as resection to be used more frequently with less risk.

For the tuberculosis patient, too, these advances have helped to spell less hospitalization and more home care. Patients are now spending only about one third of the time in hospitals and sanatoria that they spent eight years ago.

In the five year period beginning in 1952, average length of hospitalization declined from sixteen months to slightly more than eight months. The time TB patients were on post sanatoria drug treatment, however, went up almost fourfold—from six months to slightly under 24 months.

The disease still remains a major national problem, costing the nation an estimated $725,000,000 a year. Major trends in tuberculosis costs are increases in hospitalization expenditures and compensation costs and a decrease in funds for construction.

Strategy is Everybody's Business*

By FRANK ROCKWELL BARNETT**

It is always a genuine pleasure for a research professor to be unchained—temporarily—from his shelf in the ivory tower and afforded the chance to inflict his *theories* on a whole roomful of practical-minded men of affairs. I hope to prove, however, that one of the *most practical*, down-to-earth assignments for the American doctor today is to become a serious student of public affairs—including politics, economic philosophy, foreign policy, national defense strategy and the educational theory that molds your children—and through them—the will and character of this nation in the time of trouble that lies before us. For the next two decades may decide the fate of man for the next 500 years, or forever.

Doctors are often very stern when they prescribe for patients who refuse to take warning signs seriously. May I, as a layman, turn the tables and be somewhat stern with this distinguished body? The "patient" in this case is the body politic: a free society which encourages individual initiative in business, law, medicine and engineering. The diagnosis for that civilization is cancer in the intestines and paralysis of the will. The prognosis is untimely and for a patient too soft to endure surgery, too undisciplined to take medicine, too purposeless to survive. It will involve intellectual therapy and moral hygiene; or, in old-fashioned terms, homework and willpower.

I hope to demonstrate that it is important for doctors to think about political muscle tone, ideological x-rays, and preventive education. I hope also to indicate that—unless at least one man out of every three in this room commits himself to an active role in public affairs—then it is unlikely that your profession will survive its competition. By "competition," I do not mean the friendly race between Blue Cross and other insurance programs. There is a new kind of "competition" abroad in the world today. This form of COMPETITION, spelled in "all-caps," is designed to destroy—utterly and for all time—the moral, legal and political framework of the civilization which undergirds our voluntary society. If Genghis Khan & Co. win this competitive struggle, there will be no second chance for freedom.

The American Voluntary Society faces two mighty competitors—World Communism and International Socialism. Some students would argue that Communism and Socialism are twin engines in the same juggernaut. But perhaps there are useful distinctions. The threat of Communism is largely external, military, scientific, political, and economic. It is an *immediate* threat. Its weapons are violence, subversion, propaganda and blackmail. The danger of Socialism is largely internal and long-range. Its weapons are education, persuasion and the ballot-box.

. . . . Is there any way out of the dilemma? One remedy is to apply the American genius for voluntary action to the realm of public affairs. But this requires that the managers and professional leaders of our society must make public affairs their avocation—their full-time hobby. They dare not hold aloof from political life and from hard intellectual effort. They will have to do their "homework" in philosophy and history. And they must not wait for another Pearl Harbor or giant depression to move them to prudent action.

. . . . In short, an Asiatic conqueror stands on our frontier. Owing to science, the Atlantic Ocean is no wider than the Rio Grande. Owing to technology, the Pacific is no broader than Lake Michigan; and the wastelands of the North can be bridged in a few hours' flight. We Americans are face to face with the descendants of Genghis Khan.

. . . . Indeed, television brings Mr. Khrushchev into millions of American living rooms to lecture on the glories and inevitable triumphs of World Socialism.

. . . . Khrushchev & Co. are no longer a rude barbarian horde. They are disciplined in science and well-armed with engineering. They are schooled in economics and political theory. They speak many languages. They have learned to use education, literature, art, trade and even religion as weapons of subversion. Above all, they are superbly trained in the conduct of symbol-warfare—in *conquest by communication* and *warfare by words.*

That is why we must talk about management's responsibility for public affairs and national security. In the past, wars were chiefly shooting matches, and businessmen naturally left defense problems in the hands of America's soldiers. Today, the front is everywhere. Certain intangibles can literally "wash out" the material foundations of defense. If the world climate of opinion is mobilized against us by propaganda, we will lose markets, air bases and access to strategic raw materials. If, here at home, we lose the will to sacrifice or cynically disregard our spiritual traditions, our physical wealth will not safeguard American civilization. Today, national defense begins at the level of domestic political

*Remarks presented at the annual meeting of the Conference of Presidents and other officers of State Medical Associations, San Francisco, California, June 22, 1958.

**Director of Research, the Richardson Foundation, Inc. (Note: The opinions herein expressed do not necessarily represent those of the Richardson Foundation, Inc.)

morality, the quality of citizenship training for our youth, and the reputation of American business growth both here and abroad. These "intangibles" are the clear responsibility of private citizens.

. . . History teaches us that when a people put indulgence before discipline, worship welfare and discourage risk-taking, they are likely soon to be forced into bankruptcy by a more vital competition. Especially if they no longer believe in themselves. For nearly twenty-five years this country has been confused by a cult of doubt. Too many Americans suffer an odd guilt complex about their own way of life. Meanwhile the missionaries and conquistadors of the Communist Church Militant advance Marxism as the one true faith—and they are willing to die for their belief. That is why the battles of the Cold War are fought on our side of the Iron Curtain and at the Kremlin's initiative. That is why trying to contain Communism with a Maginot line of dollars and diplomacy is bound to fail. We forget that no *status quo* power has ever checked the thrust of a dynamic barbarian—for even if the "Defense" is ninety per cent successful on every occasion, a civilization can be driven to its doom ten yards at a time.

. . . . But the greatest threat to our civilization may not stem from Soviet guided missiles or engineering of atomic weapons. . . . . It is in the realm of "Fourth Dimensional Warfare"—or psycho-social combat—that we are hopelessly outclassed. We know a lot about the tricks and techniques of mass persuasion—but we have not yet applied that knowledge to the main challenge of our time—how to beat Communism without fighting a hot war.

. . . . It is imperative, of course, for this nation to win the contest of science, electronics and military hardware. . . . . To do that, we must raise the standards and improve the quality of education in economics and philosophy, American History, political science and foreign languages—as well as in science and engineering. And we must not be afraid of competition in the classroom, for young America in the next two decades is going to face the most ruthless competition the world has ever known.

American Business cannot afford to be a mere spectator at this match for the future of mankind. The "managers" of Soviet Society are all committed to agitation and politics. They are conflict minded. You can't do business with Moscow, because Communists are not businessmen or statesmen. They are professional revolutionaries . . . . Since Communists have a combat mentality, you can't reason with them. If we don't want to fight them—or surrender—we must learn to beat them in the precincts of the Middle East, in the lobbies of the United Nations, in our own classrooms and pulpits, and before the court of world opinion. Our own managers dare not be aloof to this challenge.

. . . . Why should business be asked to serve? Primarily, because our *economic* system is the crux of the whole struggle—and because, in a sense, this is the Business Society.

. . . . One way for business to attack these complex problems systematically—and with sophistication—would be to build an Academy of Industrial Statesmanship. This would be, in effect, the equivalent of the Harvard School of Advanced Management in the area of public affairs, national defense, citizenship training, and the "theology" of American-style capitalism. Its purpose would be to produce articulate champions of freedom who could compete with the lobbyists for Marx in the never-ending battle to condition the climate of opinion.

. . . . Ultimately, it may be desirable—even necessary—for great corporations to appoint vice-presidents of public affairs to spend full time on these matters.

. . . . One word more. The ultimate weapon is neither science nor politics nor psychological warfare. The ultimate weapon is human courage—and faith in certain unalterable moral laws.

. . . . On the other hand, we Americans have developed the most flexible, continually progressing society known to man. Our so-called "masses" already enjoy luxuries undreamed of in other parts of the world . . . . But beyond that is the fact that we are truly free men. We have plenty AND freedom, together. We must not let this remarkable experiment in human liberty and opportunity perish from want of courage, or lack of sophistication, or failure to meet the problem with the ablest human resources at our disposal. That is why these questions of national strategy and public affairs urgently require the attention of this audience.

It may be argued, of course, that the profession of medicine is a thing unto itself, that doctors have no business to "intervene" in the great affairs of state. The health of a democracy depends, however, to a large degree on the quality of its participating units. If doctors are to abdicate their responsibilities as citizens, why should not engineers and scientists, college professors and bankers take a similar view? In a sense, we are all professionals; and we are also all responsible for preserving our freedoms. If we are to safeguard a society in which *political* ethics make possible *professional* ethics, we dare not leave the formation of public opinion to demagogues. American doctors who are "too busy" to engage in public affairs—or do their homework—may find, in the years to come, that they may have to spend full time in some dismal underground, as did their colleagues in Nazi Germany or as men do today in Poland, Hungary and Czechoslovakia. Never before in history have the moral implications of the Hippocratic Oath been more urgently required, not alone for medicine, but for the whole free society.

. . . . The task may seem enormous; but the stakes are even higher. And let us remember that great events are always determined by minorities . . . . There is more than enough talent in this one room to change the course of history. But time is impartial. In politics and war, as in business, time is only on that side which knows how to use it.

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Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

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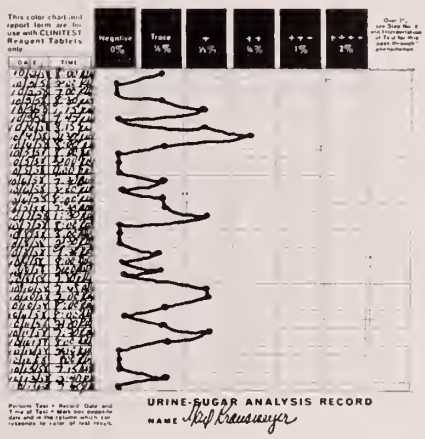

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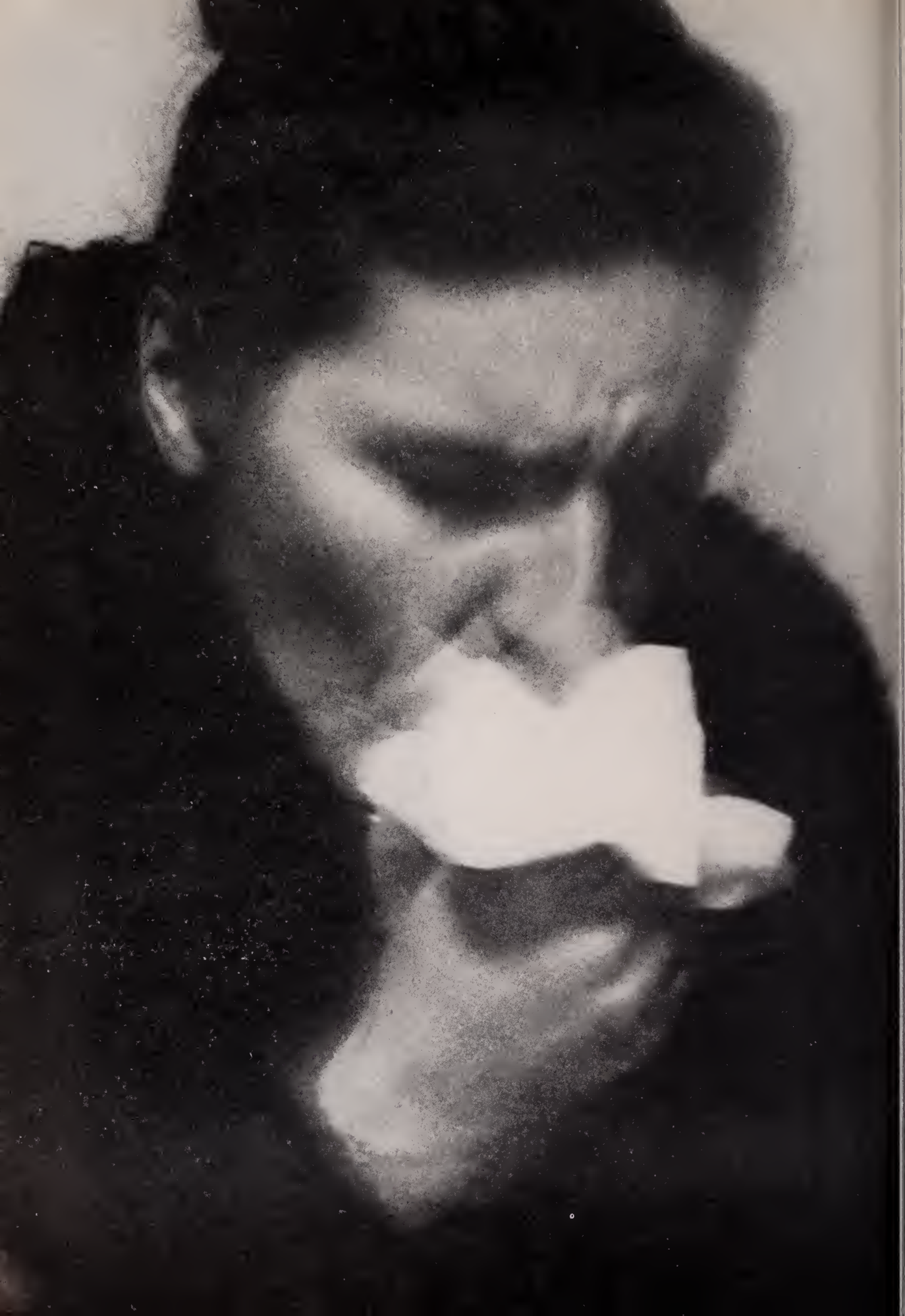

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- 'Deaner' may be prescribed with little or no concern over side effects even in the presence of liver disease, diabetes, cardiovascular disease, and a long list of other chronic conditions, except grand mal epilepsy (only contraindication).
- 'Deaner' *is not a monoamine oxidase inhibitor;* hence it is not necessary to monitor its administration with repeated, expensive laboratory tests.
- This notable freedom from side effects endows Deaner's long-term administration with easier patient supervision, better patient cooperation, and greater safety.
- Dosage is simple—initially, 50 mg. (2 tablets) daily in the morning. *Gradually, apathy and defeat are transformed into affability and renewed interest and vigor.*

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Dexamyl® Tablets • Elixir
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brand of dextro amphetamine plus amobarbital

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